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Women Empowerment and Access to Reproductive Healthcare: The Context of Rural Bangladesh

M. Phil Thesis
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Roll No-03

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Department of Anthropology

A Thesis Submitted for the Partial Fulfillment of Requirements for the Degree of Master of Philosophy in the Department of Anthropology

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Women Empowerment and Access to Reproductive Healthcare: The Context of Rural Bangladesh

A thesis submitted to the Department of Anthropology under the Faculty of Social Sciences at the University of Dhaka, Dhaka, Bangladesh, in partial fulfillment of the requirements for the degree of Master of Philosophy in the Department of Anthropology.

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Declaration

I declare that my thesis entitled "Women Empowerment and Access to Reproductive Healthcare: The Context of Rural Bangladesh" is completely of my own research work. So far I know, no research on this title has been conducted previously. I have not submitted this thesis or any part of it anywhere for any degree or publication.

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Certificate of Approval

Certified that the thesis entitled "Women Empowerment and Access to Reproductive Healthcare: The Context of Rural Bangladesh" by Helen Mannan, Roll No. 03, Registration No. 186, Session: 2009-2010, for the degree of Master of Philosophy in the Department of Anthropology, University of Dhaka, Dhaka, Bangladesh, has been carried out under my supervision. So far I know, she has not submitted this thesis or any part of it anywhere for any degree or publication.

I approve it for submission.

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Dedicated

To

Rahima Akhter

My Maternal Grandmother (Nani)

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Abstract

The present study deals with women empowerment and reproductive healthcare and the relationship between the two variables in the context of rural Bangladesh. It is generally assumed that women's reproductive healthcare depends on certain factors and women empowerment seems to be the most significant. That is why; the study has set its main objective: how and to what extent women empowerment exerts impact on women's reproductive healthcare. Based on the main objective, some other general objectives have also been decided. These are: (1) interdependence of women empowerment and reproductive healthcare; (2) present conditions of women empowerment; (3) present conditions of reproductive healthcare; and (4) obstacles the rural women face in accessing to standard reproductive healthcare. Keeping congruity with the stated objectives, the study has built certain hypotheses and attempts have been made to test those hypotheses all along the study. The study is based mainly on the primary sources of data and information collected from *Hazipur*, the research field of the study. In addition, the secondary sources of data and information have also widely been used in the study.

The study has explored some unearth phenomena about women empowerment and reproductive healthcare of the rural women of Bangladesh. Of particular, the study has assessed the impact of women empowerment on the access to standard reproductive healthcare. It has been found that women empowerment is a significant variable in this respect. Of all the areas of women empowerment, empowerment in family domain is the most significant factor in accessing to standard reproductive healthcare. It is because of the fact that a rural woman's life is fully dominated and controlled by the patriarchic family system, and she

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has no effective sharing in family decisions. Similarly, a woman has no sharing in healthcare decision rather it is monopolized by male members of the family. Therefore, having no sharing in family decisions negatively affects women's reproductive healthcare.

On regard to social empowerment and its impact on reproductive healthcare, the study reveals that the rural women of Bangladesh are in real sense excluded from social power and position. Rather social powers are monopolized by the male members of the family. A woman's social identity is also made by head of the family and/or husband. Women are hardly permitted to participate in religious and social gatherings and festivals. Therefore, woman's social role is very much marginal and this type of role has little positive effect on women's reproductive healthcare. The study also reveals that husband's social position is hardly used in favor of wife's healthcare. Therefore, it seems that women's powerlessness in the society negatively affects their reproductive healthcare.

The study has assessed the impact of economic empowerment on the access to standard reproductive healthcare. It has been found that economic factor is the most vital one on women empowerment but the rural women are mostly deprived of resource endowment. Their works are not recognized as productive ones and these are valued accordingly. Most of the rural women are engaged in household work which is unpaid. All these factors made the women economically 'dependent' on male. As a result, the women have hardly meaningful participation in financial decisions which negatively affects women's reproductive healthcare.

The rural women are very apolitical and at best seasonal political participants. Political powers are monopolized by the male members of the society. The study reveals that women's powerlessness in political arena deprives them in accessing

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standard reproductive healthcare. They can only exercise their voting right but this right is also to a large extent deviated from their personal choices which is called client voting. Therefore, lack of political power deprives the rural women of getting adequate and standard reproductive healthcare services.

Finally, the study concludes that apart from other factors the access to standard reproductive healthcare largely depends on women empowerment. At the same time, women empowerment also to some extent depends on women's reproductive health and healthcare. Both the variables are significantly intertwined. Therefore, women empowerment is an important prerequisite for accessing standard reproductive healthcare.

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Glossary

Ak ghore	:	Exclusion from society
Allah	:	Allah is the most powerful supernatural being in Islam
Atur ghar	:	Room of seclusion
Ayah	:	Nurse/who takes care
Babar barir ador	:	Take care of father's home
Bagan	:	Garden
Baganbari	:	Fragmented part of the research area
Ballo bibah	:	Early marriage
Baliati	:	Northern side village of the research area.
Bengali	:	An ethnic group/community who speaks Bangla.
Charpara	:	Eastern side village of the research area.
Choa/napak	:	Polluted
Dai	:	Midwive
Eid-gah	:	The place where Muslim take prayer during Eid day
Fakirbari	:	Fragmented part of the research area
Gosthi	:	Clan
Hazipur	:	The name of the research area
Hekim	:	Traditional village doctor
Imam	:	The head of a mosque
Jamider	:	Landlord
Jumma	:	Friday prayer in Islam
Kabiraj	:	Traditional village doctor
Kancha	:	Raw
Kaunmara	:	Southern side village of the research area
Kitton	:	The praising songs about Radha and Krishna
Lajuk	:	Shy
lojjaboti	:	Shy

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Lord Krishna	:	One of the most powerful gods among Hindu people.
Manikgonj	:	Name of the research area District
Matabbar	:	The head of a village
Matabbar/matbar /morol	:	Head of a village
Miabari	:	Fragmented part of the research area
Moddyapara	:	Fragmented part of the research area
Moqtab	:	Religious school
Moulana	:	Muslim religious teacher
Mawlana	:	religiously educated person in Islam
Naogaon	:	Western side village of the research area
Nongra	:	Polluted.
Ojha	:	The doctor of/about ghost.
Pani pora	:	The holly water from religious people.
Pakutia	:	Name of the research Union.
Payee hata path	:	Mud made road for walking.
Pir	:	Religious man who has supernatural power.
Purdah	:	Curtain/veil.
Quran	:	The holly book of Islam.
Radha	:	Goddess who is the lover of Krishna.
Sabuj Sata	:	Local government hospital.
Suftee	:	Religious man who has supernatural power.
Salish	:	Judgment.
Samaj	:	Society.
Samitee	:	A group of people who have some rules to obey which can be social, political, economic.
Saturia	:	Name of the research Thana.
Uttarpara	:	Fragmented part of the research area.
Valo mondo	:	Good and nutritious curry food.

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Abbreviations

ANC	:	Antenatal Care
AL	:	Awami League
ASRM	:	American Society of Reproductive Medicine
BDHS	:	Bangladesh demographic and Health Survey
BNP	:	Bangladesh National Party
CEP	:	Center for Environment and Population
CINI	:	Child in Need India
CMNS	:	Child and Mother Nutrition Survey
CSBA	:	Community Skilled Birth Attendant
ESHRE	:	European society of Human Reproduction and Embryology
DAWN	:	Development Alternatives with Women for a New Era
FGM	:	Female Genital Mutilation
FWV	:	Family Welfare Visitor
GDI	:	Gender-Related Development Index
GDP	:	Gross Domestic Production
GEM	:	Gender Empowerment Measure
HEB	:	Health Education Bureau
HIV	:	Human Immunodeficiency Virus
HRP	:	Human Reproduction
ICPD	:	Conference on Population and Development
IMF	:	International Monetary Fund
INC	:	Intranatal Care
LBW	:	low Birth Weight
MA	:	Medical Assistant
MDGs	:	Millennium Development Goals

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MGM	:	Male Genital Mutilation
M.PHIL	:	Master of Philosophy
NGO	:	Non-Governmental Organization
PHC	:	Primary Health Care
PONC	:	Postnatal Care
PRSP	:	Poverty Reduction Strategy Papers
SACMO	:	Sub Assistant Community medical officer
STD	:	Sexually Transmitted Disease
SWA	:	Family Welfare Assistant
TBA	:	Trained birth Attendant
UN	:	United Nations
UNDP	:	United Nations Development Program
UNFPA	:	The United Nations Population Fund
U.S	:	United States
WB	:	World Bank
WHO	:	World health organization

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Chapter 1

Problems and Methods

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Chapter 1

Problems and Methods

1.1: Introduction

Women constitute about half of the world's population. But disparity between men and women in all walks of life is the dominant feature of the present world. Of the 1.3 billion people who live in absolute poverty around the globe 70 percent are women. Women work two-thirds of the world's working hours; Women earn only 10 percent of the world's income; Women own less than 1 percent of the world's property; Women make up two-thirds of the estimated 876 million adults worldwide who cannot read or write.[1] At the same time it can be said about challenges, problems and issues, women's health, healthcare and well-being. Demographically, rate of mortality and morbidity, infant and child mortality, ill-health, malnutrition are many times higher in women than men, which made a gender inequality as well as social disparity within the society. All other indices of health demonstrate women's inferior position in rural and urban Bangladesh and also everywhere of the world.

From our understanding and perception, it is a reality that no nation can achieve development without the participation in the process of development by the female population and for this purpose, 'women empowerment' is necessary in all sectors. In this context, the present stud has to be attempted and endeavor that it is especially required adequate scientific and modern reproductive healthcare for women everywhere of the society. According to Vicky Markham, "Empowering women through education, legal rights, healthcare, and economic opportunities is good for women and good for the planet." Scholars and others said that family planning and reproductive healthcare is one of the most

inexpensive and powerful development strategies to achieve women empowerment. Despite the necessity over 215 million women worldwide still lack access to these services.[2] Though Bangladesh is a traditional country, it can be said that women empowerment is necessary for the access to standard reproductive healthcare.

The U.S. spends at least twice as much per capita on healthcare than almost every other western industrialized country.[3]In compare to U.S. all developed western countries follow the same rule. They usually prefer the health sector as they believe that 'health is wealth'. According to them, to gain prosperity in every walk of life, people have to have healthy life. Those industrialized, technologically advanced, modern western countries give more preference to female health and their empowerment as they think women as their partners in everywhere. For these reasons, women in western countries are properly healthy, active, and productive as well as empowered in their all spheres of life.

The poor disproportionately bear the consequences of poor reproductive health, impoverished women and young people. There are glaring disparities in access to reproductive healthcare between rich and poor, within and among countries.[4] Complications during pregnancy and childbirth is a leading cause of ill health and disability among women in the developing countries. Virtually all maternal deaths (99 percent) occur in developing countries. Africa and Asia together account for 95 percent of the world's maternal deaths and less than 1 percent occur in the developed regions.[5] Therefore, disparity in women's reproductive healthcare between rich and poor countries is a significant phenomenon of the modern world.

Not only in Bangladesh but also worldwide population explosion is one of the main concerns to the social scientists, world leaders, governments, scientists, and even general mass people. Our resources are limited and by this limited

resources we cannot support the huge population. In Bangladesh, the scene is much more obvious than any other countries because of it's over population. In the 18th century, English economist Thomas Malthus's theory on the population was based on the assumption that the population would increase faster than the food supply. He argued that population growth would eventually reach at a resource limit and any further increase would result in a population crash caused by famine, disease, or war.[6]With the advent of advanced food technology in the modern world, Malthusian theory on population may be obsolete in the developed countries but still applicable to the context of Bangladesh. Therefore, planned population is an urgent need for Bangladesh.

Bangladesh, a Third World country, lacks many basic services to provide for its citizens mainly female citizens. Unlimited poverty, lack of proper education, gender discrimination, traditional belief, discriminatory class structure, poor healthcare services, traditional religious belief etc. are the main causes for which female members of Bangladesh usually cannot get proper reproductive healthcare. As a result, they own poor health and reproduce unplanned, unhealthy and malnutritious children. With a huge number of malnutritious, unhealthy citizens a country likes Bangladesh and elsewhere in the world cannot make suitable policy and strategy to achieve development.

In Bangladesh, women constitute about half of the country's total population. In this context, real development in the country is not possible without addressing women's issues and participation of women. So, this is a great problem and obstacle for the society to achieve its development goal. Women are called the second sex and are neglected by men. They are the most vulnerable section of the population and deprived of their basic needs and human rights. The rural women in Bangladesh are living in worst condition. They are the most neglected part and backward section of the country's population. Due to patriarchic social

system, economic backwardness, lack of education, traditional way of life women have very little voice and power in their family and society. In the decision making of the family and society male members usually do not give importance to women. As a result, care and services in the family are unequally distributed between men and women. Particularly, women's reproductive healthcare in rural Bangladesh is a negligence phenomenon both in family and society. The male members of the family take reproductive problems as very natural matters. During pregnancy, most of the women cannot consult with doctor, cannot take nutritious food and rest etc. They are deprived of other reproductive rights as well. Access to standard and adequate reproductive healthcare is possible when the rural women will be empowered. Therefore, it is an urgent need for the nation to deal with women empowerment and reproductive healthcare of the rural women of Bangladesh. Based on this imperative, the research problem of the present study has been designed.

Over the past few decades, impressive studies have been made in reducing levels of infant and child mortality and in increasing levels of contraceptives use in developing countries. In Bangladesh, the reduction in levels of maternal mortality and improvement of maternal health have been a central policy and program since the Fourth Population and Heath Program which began in 1992. Efforts to address these issues have recently gained considerable momentum with the formulation of the National Strategy for Maternal Health.[7]

In recent years somehow the scene is going to be changed though not in high rate and sufficient magnitude. In these days in Bangladesh, educational support to national health program has been provided by the Health Education Bureau (HEB). Emphasis has been given in recent years to school health education, hospital health education and coordination with NGOs. Constraints include the lack of a national IEC strategy, the low priority given to health education by the

health services, under-utilization of health education officers, and lack of opportunities for professional advancement of those working in health education. Some issues under considerations are the inclusion of a health education component in the new national health policy and strengthening of coordination among the HEB, ongoing government health programs and NGOs.[8] At the same time the government has to be committed to fulfill the aim and goal of Millennium Development Goal (MGDs) which is very much related with reproductive healthcare.

Development of Bangladesh society largely depends on women empowerment and reproductive healthcare. In recent years, how to solve all these reproduction related problems and remove the obstacles to women empowerment are the main issues in policy making arena, NGOs, social scientists debate, advocacy of women rights etc. There are some proposals in this respect:

1. "Health for all"- this principle should be implemented in every corner of the country;
2. "Education for all"- this policy should be highlighted and realized everywhere in the country;
3. In order to reduce poverty, government and non-governmental organizations should come forward;
4. Male-female or gender discrimination inherent in state, society and family should be removed;
5. Reproductive healthcare related facilities should be more scientific, advanced and modern;
6. Both public and private hospitals and clinics should take more necessary actions to develop their technologies which are directly related to reproductive healthcare;

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7. Knowledge to reproductive health and healthcare should be more vast and scientific; and

8. Women should get more powers in the family, social and political domain so that they may have easy access to standard reproductive healthcare.

The present study is on women empowerment and reproductive healthcare of the rural women of Bangladesh. The study investigates and analyses the present conditions of women empowerment and reproductive healthcare. Most importantly the study examines the impact of women empowerment on their access to standard reproductive healthcare. At the same time, the interrelationship and interdependence of the two variables has also been investigated.[9]In this context, the present study emphatically deals with contemporary problems and issues of women's reproductive healthcare and empowerment in Bangladesh rural society at large. However, this problem and issue has yet not properly been addressed by anthropologists and social scientists and other stakeholders. Therefore, the present study will empirically explore, describe and analyze some unearth phenomena of women's reproductive healthcare and empowerment.

1.2: Statement of the Research

In recent times, women empowerment has been a focal point in the literatures of women, gender and development. Powers for women are necessary to make them free from all sorts of violence made by family, society, religion, caste, ethnicity, class etc. They should have necessary powers and rights in all spheres of live for their survival as well as development. A reproductive healthcare or reproductive right is one of the most important aspects in which women should be empowered. But access to standard reproductive healthcare is very much dependent on women empowerment and some other factors. In fact, women

empowerment makes reproductive rights realizable. Reproductive rights derive from the recognition of the basic right of all individual couples to make decisions about reproduction free from discrimination, coercion or violence. They include the right to the highest standard of health and the right to determine the number, timing and spacing of children. They comprise the right to safe child-bearing, and the right of all individuals to protect themselves from HIV and other sexually transmitted infection. But all those rights particularly access to standard reproductive healthcare largely depends on women empowerment as a whole. At the same time, rights to reproductive healthcare indicate women empowerment. Therefore, women empowerment and women's reproductive healthcare are two significant interrelated and interdependent elements in the literature of women, gender and development.[10] That is why, it is imperative to conduct a research on women empowerment and access to reproductive healthcare, and the interrelation between the two variables. The present study, therefore, deals with women empowerment and access to standard reproductive healthcare, and the interrelation and interdependence of the two variables in the context of rural Bangladesh.

1.3: Objectives of the Study

The present study has been designed to focus on the empowerment and access to reproductive healthcare of the rural women of Bangladesh. The broad objective of the study is to assess the impact of women empowerment on reproductive healthcare and access to reproductive system. The specific objectives are as follows:

Specific Objectives

1. To investigate and analyze the present conditions of women empowerment in rural Bangladesh;

2. To investigate and analyze women's present conditions in accessing to standard reproductive healthcare services;
3. To investigate and analyze the present conditions of women's reproductive healthcare;
4. To investigate and analyze the obstacles face the women to accessing to standard reproductive healthcare services.

1.4: Hypotheses of the Research

The study has taken hypotheses which are congruent with the stated objectives. Attempts have been made to test the hypotheses all through the study. The taken hypotheses are following:

Hypothesis I

From general observation, it seems that in a patriarchic society like rural Bangladesh women can hardly exercise any rights. Reproductive rights particularly access to standard reproductive healthcare largely depends on the extent of rights women enjoy in all walks of life. Therefore, women empowerment is a vital prerequisite for accessing to standard reproductive healthcare.

Hypothesis II

Access to reproductive healthcare also facilitates women to be empowered. Access to standard reproductive healthcare is a condition as well as result of women empowerment. As a healthy woman is expected to play her proper role in family and broader society which makes her empowered in return.

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1.5: Rationale of the Study

In Bangladesh, bulk of the population lives in the rural areas and about 49.5% of them are women. The rural women are the most neglected and backward section of the country's population. Due to patriarchic social system, economic backwardness, lack of formal education, traditional way of life women have very little voice and power in their family and society. In the decision making of the family and society male members usually do not give importance to women. Female body is not for herself, she has no right on it. They are treated as a means, not an end. In any kind of disease or health problem they usually cannot get any care and treatment rather get negligence. Particularly women's reproductive healthcare in rural Bangladesh is a negligence phenomenon. The male members of the family think that reproductive problems are very natural. During pregnancy most of the women cannot consult with doctor, cannot take any special care, food, rest etc. They are deprived of other reproductive rights as well. Access to standard and adequate reproductive healthcare is possible when rural women are empowered.

Bangladesh is one of the poorest countries of the world. Most of the people living in this South Asian country cannot meet their fundamental basic human rights such as food, education, shelter, medicare facilities, clothing etc. Because of economy and infrastructural situation, the government also cannot or do not help people adequately in their crisis moments. As a predominated patriarchal social system the sexual division between genders as male and female has played a vital role of disparity, oppression and exploitation. Naturally women are subordinate and inferior to men in all walks of life. From the early childhood a girl child usually experiences the differential and discriminatory behavior between her and her brother(s) by their parents and society. She grows up with physically and mentally ill-health. Rural women and girls experience this

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condition more than urban women. Most of them suffer from ill-health. Though in recent years, women's health is getting much importance but this is not enough. Bangladeshi rural women suffer much from poverty, and they lack adequate nutritious food, clean water and sanitation, medicare facilities, education, leisure and reproduction; above all they live in underpowered condition in family and society. Gender discrimination, poverty, unfavorable demographic conditions, traditional knowledge, attitude, practice, environment etc. have made women the most under privileged section of the population.

Reproductive healthcare and women empowerment are very much interrelated and interdependent. Because the women who are more empowered, get better reproductive healthcare facilities, and on the other hand, powerless women get less reproductive healthcare facilities. This study however deals with women empowerment and access to reproductive healthcare in the context of the rural women of Bangladesh. The study will be helpful for the disciplines of social sciences like anthropology, sociology, political science, public health, development studies and gender studies etc. It is not only an academic purpose but also action and applied policy makers on health would be benefited from the study; because the study opens up many significant related with the female and child health as well as rural women's traditional and nonscientific measures during pregnancy and child birth. Even general mass people of Bangladesh can know about various aspects of female health, reproductive health, child birth, pregnancy related complications, obstacles to get the proper medicare facilities during pregnancy, the real situation of the empowerment of women, how patriarchic social system dominate women through the study. The study endeavors all concerned of anthropological understanding to many basic matters relating to women empowerment and reproductive healthcare.

1.6: Methods of the Study

1.6.1: Variables of the Study: Dependent and Independent

In the cause-effect relations, variables are classified into three: (1) dependent variables; (2) independent variables; and (3) controlled variables. Independent variables are also called explanatory variables or causal variables, and dependent variables are called outcome variables.[11] In this study, "women's reproductive healthcare" has been used as dependent variable and "women empowerment" as independent variable. All other factors except women empowerment which exert impact on women's reproductive healthcare are controlled variables and these variables have not been dealt with in this study. Operational definitions of both dependent and independent variables have been given below:

1.6.1 (a): Reproductive Healthcare: Dependent Variable

Health is the level of function or metabolic efficiency of a living being. In humans, it is the general condition of a person's mind, body and spirit, usually meaning to be free from illness, injury or pain as in "good health" or "healthy." The World Health Organization (WHO) defined health in its broader sense in 1946 as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[12]

The maintenance and promotion of health is achieved through different combination of physical, mental, and social well-being, together sometimes referred to as the "health triangle." The WHO's 1986 Ohawa Charter for Health Promotion furthered that health is not just a state, but also "a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources as well as physical capacities."[13]

Systematic activities to prevent or cure health problems and promote good health in humans are delivered by healthcare providers. Applications with regard to animal health are covered by the veterinary sciences. The term "healthy" is also widely used in the context of many types of non-living organizations and their impacts for the benefit of humans, such as in the sense of health communities, health cities or healthy environments. In addition to healthcare interventions and a person's surroundings, a number of other factors are known to influence the health status of individuals, including their background, life style, and economic and social condition, those are referred to as "determinants of health."

Reproductive health is a holistic concept; a state of complete physical, mental and social well-being and not only merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have capability to reproduce and the freedom to decide it, and how often to do. Reproductive healthcare has been analyzed in details in chapter 3.

1.6.1 (b): Women Empowerment: Independent Variable

Empowerment

Empowerment refers to increasing spiritual, political, social, educational, economic strength of individuals and communities. The term empowerment covers a vast landscape of meanings, interpretations, definitions and disciplines ranging from psychology and philosophy to the highly commercialized self-help industry and motivational sciences.[14]

Sociological empowerment often addresses the members of groups that social discrimination processes have excluded from decision making processes for

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example—discrimination based on disability, race, ethnicity, religion or gender. Empowerment as a methodology is often associated with feminism.[15]

Women Empowerment

Empowerment of women, also called gender empowerment, has become a significant topic of discussion in regards to development and economics. Entire nations, businesses, communities and groups can benefit from the implementation of programs and policies that adopt the notion of women empowerment.[16] Empowerment is one of the main procedural concerns when addressing human rights and development. The human development and capabilities approach, the millennium development goals, and other credible approaches/goals point to empowerment and participation of women as a necessary step if a country is to overcome the obstacles associated with poverty and development.[17]

Empowerment begins when women change their ideas about the causes of their powerlessness, when they recognize the systematic forces that oppress them, and when they act to change the conditions of their lives. Empowerment is the capacity of women to increase their own self-reliance and internal strength. This is identified as the right to influence the direction of change through the ability to gain control over crucial material and non-material resources.[18]

Several academic scholars and gender experts have made outstanding contributions to the growing discipline of gender studies and there is considerable theoretical discussion on the subject of empowerment. Recently, Gita Sen and Srilatha Batliwala give a widely quoted definition of women's empowerment:[19]

> Empowerment is the process by which the powerless gain greater control over the circumstances of their lives. It includes both control

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over resources (physical, human, intellectual, financial) and over ideology (beliefs, values and attitudes).

Elaborating further on this definition, Gita Sen and Batliwala write:[20]

> It means not only greater extrinsic control, but also a growing intrinsic capacity—greater self-confidence and an inner transformation of one's consciousness that enables one to overcome external barriers to accessing resources or changing traditional ideology. Genuine empowerment includes both these aspects and can rarely be sustained without both. A development program that changes women's control over resources must also build their confidence in themselves, if women are to have the resilience and motivation to retain and build on that control. Vice versa, programmes that change awareness without leading to greater access to material resources can lead to frustration and high dropout rates.

John Hobcraft, a noted demographer, discusses female empowerment in relation to child well-being. He quotes Batliwala's definition of female empowerment as follows:[21]

> The most conspicuous feature of the term empowerment is that it contains the word power, which, to side-step philosophical debate, may be broadly defined as control over material assets, intellectual resources, and ideology. The material assets over which control can be exercised may be physical, human, or financial, such as land, water, forests, people's bodies and labor, money, and access to money. Intellectual resources include knowledge, information, and ideas. Control over ideology signifies the ability to generate, propagate, sustain, and behavior—virtually determining how people

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perceive and function within given socio-economic and political environments.

Amartya Sen in his book *Development as Freedom* (1999) considers empowerment as enhanced freedom. To quote him at length:

> The empowerment of women, through employment opportunities, educational arrangements, property rights and so on, can give women freedom to influence a variety of matters such as intra family division of health care, food and other commodities and work arrangements as well as fertility rates, but the exercise of that enhanced freedom is ultimately a matter for the person herself. The fact that statistical predictions can often be plausibly made on the ways this freedom is likely to be used (for example, in predicting that female education and female empowerment opportunity would reduce fertility rates and the frequency of child bearing) does not negate the fact that it is the exercise of the women's enhanced freedom that is being anticipated.[22]

From more operational point of view, women empowerment in this study has been perceived from four dimensions: (1) empowerment in family domain; (2) social empowerment; (3) economic empowerment; and (4) political empowerment. It seems that the above mentioned four dimensions will present a real understanding of women empowerment.

Measuring Women Empowerment

Women empowerment can be measured through the gender empowerment measure, (GEM). The GEM shows women's participation in a given nation, both politically and economically.[23] GEM is calculated by trashing the share of seats in parliament held by women; of female legislators, senior officials and managers; and of female profession and technical workers; and the gender

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disparity in earned income, reflecting economic independence.[24] It then ranks countries given this information. Other measures that take into account the importance of female participation and equality include: the gender parity index and the gender-related development index.

UNDP has developed its GDI (Gender-related Development Index), which is based on the expectation of life at birth, education and income and its GEM, based on proportions of seats in parliament of administrative and managerial jobs, of professional and technical jobs, and of earned income attributable to women. These measures form a useful fires step in mapping degrees of gender inquiry between countries, but ignore key issues such as the domestic division of labor and unpaid work.[25]

Ways to Empower Women

One way to deploy the empowerment of women is through land rights. Land rights offer a key way to economically empower women, giving them the confidence they need to tackle gender inequalities. Often, women in developing nations are legally restricted from their land on the sole basis of gender. Having a right to their land gives women a sort of bargaining power that they wouldn't normally have, in turn; they gain the ability to assert themselves in various aspects of their life, both in and outside of the home.[26]Another way to provide women empowerment is to allocate responsibilities to them that normally belong to men. When women have economic empowerment, it is a way for others to see them as equal members of the society. Through this, they achieve more self-respect and confidence by their contributions to their communities. Simply including women as a part of a community can have sweeping positive effects. In a study conducted by Bina Agarwal, women were given a place in a forest conservation group. Not only did this drive up the efficiency of the group, but

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the women gained incredible self-esteem while others, including men, viewed them with more respect.[27] Participation which can be seen and gained in a variety of ways, has been arranged to be the most beneficial form of gender empowerment. Political participation, be it the ability to vote and voice opinions, or the ability to run for office with a fair chance of being elected plays a huge role in the empowerment of peoples.[28] However, participation is not limited to the realm of polities. It can include participation in the household, in schools, and the ability to make choices for one self. It can be said that these latter participations need to be achieved before one can move onto broader political participation.[29]When women have the agency to do what she wants, a higher equality between men and women is established. It is argued that micro credit also offers a way to provide empowerment for women. Governments, organizations, and individuals have caught hold of the lure of microfinance. They hope that lending money and credit allows women to function in business and society, which in turn empowers them to do more in their communities. One of the primary goals is the foundation of microfinance work women empowerment. Loans with low interest rates are given to women in developing communities in hope that they can start a small business and provide for her family. It should be said, however, that the success and efficiency of microcredit and microloans is controversial and constantly debate.[30]

Economic Benefits of Women Empowerment

Most women across the globe rely on the informal work sector for an income. If women were empowered to do more and be more, the possibility for economic growth becomes apparent. Eliminating a significant part of a nation's work force on the sole basis of gender can have detrimental effects on the economy of that nation. In addition, female participation in counsels, groups, and business is seen

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to increase efficiency. For a general idea on how an empowered woman can impact a situation monetarily a study found that of fortune 500 companies, "those with more women board directors had significantly higher financial returns, including 53 percent higher returns on equity, 24 percent higher returns on sales and 67 percent higher returns on invested capital.[31] This study shows the impact women can have on the overall economic benefits of a company. If implemented on a global scale, the inclusion of women in the formal workforce (like a fortune 500 company) can increase the economic output of a nation.

Barriers to Women Empowerment

Many of the barriers to women empowerment and equity lie ingrained into the culture of certain nations and societies. Many women feel these pressures; while others have become accustomed to being treated inferior to men in the literature is called internalization process. Even if men, legislators, NGOs, etc. are aware of the benefits women empowerment and participation can have, many are scared of disrupting the status quo and continue to let social norms get in the way of development. As a poor and backward society Bangladesh is confronting a number of barriers to its women empowerment.

1.6.2: Population and Samples

In the present study area, there are 398 women who have given birth at least one child. It consists of the vital part of the population of this study. The study has selected 326 women as sample size, which covers 82% of the total married women and given birth at least one child. The rest of the 18% women were not available to respond during my fieldwork. Apart from these selected samples, the study has collected data from a diverse group of the population. They include: heads of the family, husbands, *matabbar*, *imam*, *moulana,*

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midwives/*dai*, family planning workers, school teachers, union parisad chairman and members, union parishad female members, *hekim* and *kabiraj*, local doctors, NGO workers, management of hospital and clinic, workers of *sabuj sata* clinic, and so on. In some cases, I have relied on my own judgment to a great extent for collecting reliable data.

1.6.3: (a) Sources of Data

In the present study, data and information have been collected from both primary and secondary sources. Both the sources have been described below:

Primary Sources: The present study has been based on primary data and its analyses. Data for this study have been collected mainly from the research field. For this purpose, a typical village of Bangladesh named *Hazipur* in *Manikgonj* district has been selected as the research area of the study. I have collected the data and information from the village during January to May 2012. In addition, data and information have been collected from some relevant persons outside of the research area.[32]

Secondary Sources: In addition to the primary sources, secondary sources have also been used as the source of some necessary data, information, ideas, analyses and concepts. Secondary sources of the study include books, journals, academic articles, newspaper, statistical yearbook, government documents, published or unpublished research reports and other social artifacts.

1.6.4: (b) Methods of Data Collection

It seems that single method for collecting data and information for this research is inadequate. That is why, a combination of certain suitable methods has been followed for this purpose. The methods are the following:

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Personal Interview: The study has collected data and information personally from the respondents by using both a structured and semi-structured interview schedule. Interview has been taken place in order for better understanding of the responses, and to observe the real conditions of the rural women's empowerment and reproductive healthcare.

Participant Observation: Along with personal interview participation observation method has been followed at a limited scale for collecting data. I permanently stayed in the study area for two and a half months and associated with the inhabitants who helped me look into the matters almost as an insider.

Focus Group Discussion: The study has organized seven focus group discussions consisting of 5 to 8 participants of my target groups. The participants discussed the problems relating to women empowerment and access to reproductive healthcare in open environment and I took audio-video records of their discussions. Thus, real and reliable data and information have been ensured.

Oral History: Through oral history method many significant facts of society come out. In this study, an oral history method has also been used to collect information. For this purpose, some knowledgeable persons have been selected to discuss.

Life History: Life history is an important method in social research. By this method, life histories of some respondents are understood. Some respondents have described their life histories relating to the issues of women empowerment and reproductive healthcare.

Case Study: Case study method has also been used in the research. By studying some cases many valuable information have been gathered for research purpose.

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Picture/Photograph: To make the condition of women empowerment and reproductive healthcare alive to the readers I have taken some photographs from the study areas. All those have made the real scenario alive.

1.6.5: Limitations of the Study

This study is not beyond certain limitations particularly from researcher's manageability point of view. A researcher's manageability mainly depends on certain factors, like time, money, merit, skill, experience, conditions of the research area, and so on. As an M. Phil thesis, I had to work within a stipulated time period which has limited the volume and magnitude of the study. But the study could overcome other constraints involved with researcher's manageability. In the research field, some difficulties faced by me but could succeed to overcome these with effective rapport building. The study has gathered a huge data but could not present many of those because of space constraint.

1.6.6: Chapter Design

The present study has been divided into nine chapters. Following are the chapters:

Chapter 1: Problems and Methods

Chapter 1 is the problemation and methodology of the study which includes the statement of the research, objectives, hypotheses, rationale, variables, population and samples, sources of data, data collection methods, limitations of the study and chapter design.

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Chapter 2: Literature Review

Chapter 2 deals with some major literature related to women empowerment and reproductive healthcare. In the process, the study has been familiar with the available literature in this field and has justified the research.

Chapter 3: Reproductive Healthcare: A Theoretical Understanding

Chapter 3 deals with women's reproductive healthcare theoretically. It is the theoretical base of the study.

Chapter 4: Demographic and Geographical Structure of the Study Area

This chapter presents *Hazipur* as the research area of the study. It discusses the location population, economy, educational institutions, transport and communication, social and religious life, healthcare, nutritional conditions, and conditions of women of *Hazipur* village.

Chapter 5: Women Empowerment in Family Domain on Reproductive Healthcare

This chapter deals with how and to what extent women empowerment in family domain influences the access to standard reproductive healthcare.

Chapter 6: Social Empowerment on Reproductive Healthcare

Chapter 6 deals with how and to what extent women's social empowerment facilitates a woman to access to standard reproductive healthcare.

Chapter 7: Economic Empowerment on Reproductive Healthcare

This chapter examines the impact of women's economic empowerment on the access to reproductive healthcare.

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Chapter 8: Political Empowerment on Reproductive Healthcare

This chapter investigates and analyses the impact of women's political empowerment on the access to standard reproductive healthcare.

Chapter 9: Conclusion

Chapter 9 is the conclusion of the study. In this chapter, some concluding remarks and recommendations have been made.

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Notes and References

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7. Michael A. Koenig, Kanta Jamil, Peter K. Streatfield, Tulshi Saha, Ahmed Al-Sabir, Shams Ei Arifeen, Kenhill and Yasmin Haque, "Maternal Health

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and Care-Seeking Behavior in Bangladesh: Findings from a National Survey", *International Family Planning Perspectives*, Ministry of Family Welfare (MOHFW), Volume- 33, Number- 2, June 2007, p

8. Encyclopedia Country Facts, Health Encyclopedia, 2012. Website: *talktalk.co.uk/reference/encyclopedia./m0034800.html*

9. A number of books, articles and research works are available on both women empowerment and women's reproductive healthcare but mutual interrelationship and interdependence of the two variables has yet not been dealt with.

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11. Charles C. Ragin, *Constructing Social Research*, Rine Forge Press, London, 1994, p. 132.

12. Loue Sana and Quill E. Beth, *Handbook of Rural Health*, Kluwer Academic/Plenum Publishers, New York, London, Moscow, 2001, p. 30.

13. *Ibid*, p. 32

14. From Wikipedia, The Free Encyclopedia. www.en.wikipedia.org/wiki/empowerment.

15. *Ibid.*

16. Severine Deneulin with Lila Shahani, *An Introduction to the Human Development and Capability Approach: Freedom and Agency,* Sterling, VA: Earthscan, 2009, p.74.

17. U.N. General Assembly, 55th Session, "United Nations Millennium Declaration" (1/55/L.2) 8 September 2000. (Online) Arailable: www.un.org/millennium/declaration/areas 552e. pdf (accessed January 2, 2008). Available: www.un.org/millennium/declaration.

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18. Caroline O. N. Moser, *Gender Planning and Development: Theory, Practice and Training*; London and New York, 1993, pp. 74-75.

19. Gita Sen and Srilatha Batliwala, "Empowering Women for Reproductive Rights" in Harret B. Presser and Gita Sen (ed.), *Women's Empowerment and Demographic Processes: Moving Beyond Cairo*, Oxford University Press, New York, 2000, p. 18.

20. *Ibid*, p. 18.

21. John Hobcraft, "The Consequences of Female Empowerment for Child Well-being: A Review of Concepts, Issues and Evidence in a Post-Cairo Context" in Presser and Sen (ed.), *Ibid*, p. 161.

22. Amartya Sen, *Development or Freedom*, Alfred A. Kraft, New York, 1999, p. 288.

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27. Bina Agarwal, *Gender and Green Governance: The Political Economy of Women's Presence within and Beyond Community Forestry*, Oxford University Press, New York, 2010.

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29. Mortha C. Nussbaum, "Introduction" in (ed.), *Women and Human Development; The Capabilities Approach*, *Creating Capabilities: The Human Development Approach,* Mortha C. Nussbaum edited, Cambridge University Press, Cambridge; 2000, pp. 1-33.

30. A. Parmer, "Microcredit, Empowerment and Agency: Re-evaluating the Discourse" *Canadian Journal of Development Studies*; Vol. 24 (3); 2003, 461-76.

31. World Survey on the Role of Women in Development; Women's control over Economic Resources and Access to Financial Resources, including Microfinance, Report of the Expert Consultation, Organized by The Division for the Advancement of Women, New York. United Nations; 2009.

32. They mainly include the government officials at thana level, doctors, nurses, and other health service providers.

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Chapter 2

Literature Review

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Chapter 2

Literature Review

In the contemporary world, women empowerment as well as development has been a global agenda. Women emancipation is a matter of great importance for a developing country like Bangladesh. For this reason, special attentions have been paid by academicians, researchers, journalist, social workers, teachers, students, government, NGOs and politicians to women's issues. As a result, a number of works on women's affairs are available. But the present study has not yet been dealt with and addressing properly. However, available literatures helped me make a theoretical and conceptual understanding about the research. The literature in a research accomplishes several purposes:[1] (1) It shares with the reader the results of other studies that are closely related to the study being repeated; (2)It relates a study to the larger, ongoing dialogue in the literature about a topic, filling in gaps and extending prior studies; (3)It provides a framework for establishing the importance of the study, as well as a benchmark for comparing the results of the study with other findings.

John Creswell offers three placement locations and these are:[2]

1. The literature is used to "frame" the problem in the introduction of the study;
2. The literature is presented in a separate section as a review of the literature;
3. The literature is presented in the study at the end: it becomes a basic for comparing and contrasting findings of the qualitative study.

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John Creswell argues that the literature can be used in any or all of these locations. This study has obviously made a separate section (chapter 2) for reviewing the literature; the study has presented its literature in details at the end in Bibliography section. Following are some major and dominant literature reviewed in the study:

Lies Ostergaard (ed.), *Gender and Development: A Practical Guide*, Routledge, London and New York, 1992.

This book seeks to explain why using a gender perspective leads to greater success in development efforts. The author demonstrates how both donors and recipients need to and can incorporate gender awareness into their development aid administration. The need to incorporate gender awareness into development efforts was recognized some twenty years ago when planners began to realize that expecting a country to develop towards modernization with the female of its population unable to take full half of its population unable to take full part in the process was like asking someone to work with one over and leg tied behind their back. The experience of donor agencies over the past twenty years has shown that the application of gender analysis and a gender perspective to development efforts enable planners to understand for health needs and priorities of both men and women. Through this understanding according to the author, aid administrators can improve the impact of their projects and above all help and motivate both genders to work together towards the successful development of their conditions. In addition, the book deals with women's health and development relation with special emphasis.

Raana Haider, *A Perspective in Development: Gender Focus*, The University Press Ltd., Dhaka, 1995.

This book examines the effect of the development process on the lives of women exploring the relationship between the process of social and economic changes on women and highlighting the gender division. A framework of gender relations is used to scrutinize the distribution of resources, assets and skills among women. It endeavors to illustrate that modernization, country to popular thinking has not been unequivocally beneficial or positive in its impact on women. A screening of a number of social indicators shows that women in spite of development continue to be disadvantaged in society. The differential impact of select indicators such as fertility, mortality, migration, nutrition, health, education, work, environment, credit and food security are examined to provide a comprehensive scenario of the status of women. According to the author, this book is envisaged as both an introduction and a source of further material for policy makers, academicians, researchers and students of development. The author also describes about women and demographic dynamics and their reproductive role is significant. The focal point in morality for women is the maternal mortality rate. This indicator is also a reflection of her reproductive role. Childbearing may be a direct cause of fatalities but indirect causes of health, nutrition and a heavy workload are aspects not given adequate attention in the totality of the women's state of wellbeing. According to the writer, a more comprehensive and holistic study of the women's condition is required.

Shamim Hamid, *Why Women Count: Essays on Women in Development in Bangladesh*, The University Press Ltd., Dhaka, Bangladesh, 1999.

This book deals with non-market work (household work) and the system of national accounts in Bangladesh. It also deals with trends in women in

development in Bangladesh, women's role in the economic sectors, legal status of women, women and politics, women and violence, women and the media, impact of free market economy and structural adjustments on women, the role of the state in promoting the development of women, the role of non-governmental organizations (NGO) in promoting the development of women, women and empowerment in Bangladesh, problems of operationalizing empowerment, monitoring empowerment etc. According to the author, the lack of bargaining power of women is one of the major factors contributing to low female wage rates. In this book, he also mentions that women's employment opportunities are mainly in low-paid and law-level jobs with limited possibilities of career advancement which restrict their income earning opportunities. According to the author, in the pursuit of life and livelihood households utilize three kinds of power: social, political and psychological. In this book, he also mentions that empowerment has been interpreted as liberation from the subordinate position of women. It is the freedom to make choices to decide for themselves their role in life and society without being bound by classic stereotype role images.

AMM Anisul Awwal, *Nutrition*: *The Foundation of Health and Development*, Published by Amm Anisul Awwal, Dhaka, 2004.

As the name indicates, this book deals with various sides of nutrition. The author of the book deals with various dimensions of malnutrition, factors contributing to malnutrition, malnutrition across population, age and sex, relationship between infection and malnutrition etc. It also deals with causes of malnutrition in Bangladesh, policies and nutritional status of adolescent girls of Bangladesh, food, nutrition and their requirements, food security and nutritional status, malnutrition and diseases, nutrition and reproductive health etc. According to the

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author, it is important to recognize that the underlying causes of malnutrition namely household food insecurity, inadequate childcare and insufficient basic services exists within a broader macro-economic and political context. He also mentions that amongst all the manifestations of malnutrition, LBW is the most visible stigma of poor maternal health and nutritional status before and during pregnancy. This book also deals with areas of nutritional caring practice such as—food supply, food processing, diet planning, feeding practices, general social development etc. It also indicates common household caring practice such as—in planning diet, in food shopping, in preparation, in cooking, common national level caring practice that we can adopt etc.

Rosemarie Tong, *Feminist Thought: A Comprehensive Introduction*, Westview Press Inc, London, 1989.

This book deals with the varieties of feminist thoughts. It deals with several feminist theories such as liberal feminism, Marxist feminism, radical feminism, psychoanalytic feminism, socialist feminism, existentialist feminism and postmodern feminism. Among those, radical feminism is the school of thought where another writer discusses about women's oppression. She discusses reproduction as the cause of women's liberation etc. According to the author, radical feminists have directed attention to the ways in which men attempt to control women's bodies. She also mentions that radical feminists have explicitly articulated the ways in which men have constructed female sexuality to serve not women's but men's needs and interest. According to the author, this book is truly an introduction to some major themes in feminist thought.

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Park K. Parks, *Textbook of Preventive and Social Medicine*, 16th edition, M/S Banarsidas Bharat Publishers, India, 2000.

This book deals with people, their health, diseases and medicine. The author of this book discusses about respiratory infections, intestinal infections, arthreopodborn infections etc. This book is very helpful to understand demography and family planning, nutrition and health, environment and health, occupational health, communication for health education, healthcare of the community and many more. This book deals with organic and inorganic nutrient complexes contained in food. It also deals with fertility trends in subcontinent and family planning situation.

Henry B. Perry, *Quest for a Healthy Bangladesh: A Vision for the Twenty First Century*, The University Press Limited, Dhaka, Bangladesh, 1999.

It is an in-depth assessment of numerous health and family planning activities underway in Bangladesh. Maternal and child health issues get priority in this book. The conditions of mother and child health are the important subject matters in this book. This book shows that low birth weight, which in Bangladesh is primarily due to malnutrition, is a major contributing factor to infant mortality. It also deals with the chronic malnutrition, hunger, delivery condition of women both in rural and urban Bangladesh. But it is not a research work in real sense.

Blanchet Therese, *Women, Population and Marginality: Meanings and Rituals of Birth in Rural Bangladesh*, The University Press Limited, Dhaka, Bangladesh, 1984.

This book deals with rural women's culture, beliefs in pollution etc. Women's attitude towards pollution, polluted blood and women's health, rituals of first

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menstruation have been dealt in this book. This book also deals with women's pollution and fertility in nature, women's pollution and health, birth and death as ritual expressions of the two poles of Bengali Muslim culture, pollution and its three levels of meaning. Birth practices are important where ideas regarding conception, pregnancy, the house of birth have been described. The role and status of *dai (*midwives) in Bengali Muslim society is also important. Pregnancy and its relationship with environment and culture have been ignored here.

M. Mahbub Ullah and Anwar Islam (Edited), *Gender and Human Resources for Health in South Asia: Challenges and Constraints*, University Grants Commission of Bangladesh and Canadian International Development Agency, Canada, 2006.

This book deals with human resource, health, reproductive health at the grassroots, role of female field workers, gender dimension of health, human resources in Bangladesh. Women's access to healthcare services in rural Bangladesh has been significantly described here. "Women and health in Bangladesh: persistence and inequalities for and some remedies," "gender and human resources" "health: the case of Bangladesh" are impatient articles. Male involvement initiatives in the reproductive health program of Bangladesh from gender perspective are also important topics in this book.

Afsana Kaoser and Rashid Faiz Sabina, *Discoursing Birthing Care: Experiences from Bangladesh*, The University Press Limited, Dhaka, Bangladesh, 2000.

The book analyses the origins, development and methods of birthing care, health program, conceptualizing birthing care. Beliefs and practices related with

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childbirth are also significant here. Normal and complicated childbirth, women's perceptions and child birth, place of delivery, family care, pollution, '*atur ghar*', labor pain and pregnancy all are significant points and discussion in this book. Quality of care, maternity and healthcare, TBA, decision making and family role all have been discussed in this book.

Swapna Mukhopadhyay (edited), *Women's Health: Public Policy and Community Action*, Sage, London, 1992.

This book presents a macro scenario on health where planning for women's health is important. Micro studies on gender and reproduction is important part where poverty, gender inequality and reproductive choice, the contours of reproductive choice for poor women are important. Reaching women through children at CINI is important here. Female health issue has get little emphasise here. Pregnancy, maternal and child care etc have also been ignored.

Swapna Mukhokpadhyay and R. Savrthri, *Poverty, Gender and Reproductive Choice: An Analysis of Linkages*, The University Press Limited, Dhaka, Bangladesh, 1998.

This book has been written in the context of India. It deals with economic development, population policy and reproductive choice. Poverty, gender inequality and reproductive choice are important parts in this book. Policy scenario on women's health in India is also important here. Some experiences can be learnt from the book as the Bangladesh case in almost similar with India's case.

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Alia Ahmed, *Women and Fertility in Bangladesh*, Sage Publications, London, 1991.

It is a research work which deals with the status of women and fertility determination in traditional societies. The status of women in Bangladesh is an important part in this book. The role of socio-economic structures and policies in determining the status of women in Bangladesh has been dealt with in this book with importance. The status of women and value of children is another part here. The status of women, uncertainly and the demand for children, the socio-economic status of women and the costs of fertility regulation are important in this book. It is an authentic book on fertility in Bangladesh.

Wasim Almuz Zaman, *Public Participation in Development and Health Programs: Lessons from Rural Bangladesh*, The University Press of America, New York, 1984.

This book deals with theoretical organizations in rural Bangladesh. Economic and demographic context have been dealt with in this book. This book also focuses on public participation in rural development programs. Public participation in rural health programs, opportunity indicator of participation, prevalence indicator of participation and some recommendations are also important in this research based book. The writer also deals with costs of participation and local constituencies.

David R. Phillips and Verhasselt et. al., *Health and Development*, Routledge Publication, London and New York, 1994.

This book deals with health and development, global environmental change and health. Economic crisis, adjustment and the impact on health is also significant here. It also focuses on traditional medicine, its extent and potential for

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incorporation into modern nation health systems. This book also deals other the global pharmaceutical Industry, health development and business. The writer importantly focuses the health of women, beyond maternal and child health, maternal and child healthcare strategies. Primary healthcare, the poorer third world, healthcare in the third world have been dealt with in this book.

Sana Lous and Beth E. Quil, *Handbook of Rural Health*, Kluwer Academic/Plenum Publishers, New York, 2001.

The book focuses on the rural health and health policy. it deals with certain methodological issues in rural health research and care. Public health issues are also significant in this book. The writer also focuses on the equity in rural health and healthcare, ethic issues etc. Rural women's health is very much significant part in this book. This book also deals with infectious diseases, chronic diseases in rural health, rural occupational health and safety, oral health, rural mental health services, health education etc.

K. M. Ashraful Aziz and Clarence Meloney, *Life Stages, Gender and Fertility in Bangladesh*, International Center for Diarrheal Disease Research Bangladesh, Dhaka, Bangladesh, 1986.

This is a research based book with different stages of human life in Bangladesh. The strong relationship between cultural factors and fertility has been analyzed in this book. Authors emphasized beliefs about family size determination, miscarriage, health, infant mortality, number of children, psychological benefits as most significant phenomena. Fertility control and stages of life, family planning in different life stages are also considered as important factors. Sexual relationship and range of sexual behavior are vital factors.

Ministry of Health and Family Planning, *Maternal, Neonatal and Child Health Programs in Bangladesh*, Government of the People's Republic of Bangladesh, Dhaka, 1986.

This research monograph series deals with the real condition of mothers and child healthcare in Bangladesh. Demographic and socioeconomic situation is important here to understand maternal, neonatal and child healthcare in Bangladesh. It also deals with policy making in the health and population sectors of Bangladesh. Rural scenario is also significant here, primary health care (PHC) is another significant topic of discussion here.

Ann Bowling, *Research Methods in Health: Investigating Health and Health Services*, Open University Press, Buckingham, Philadelphia, 1997.

This book deals with the research techniques on health. It focuses on health and health services aim to understand people's perceptions, behaviors and experiences in the face of health and illness, their experiences of healthcare, their coping and management strategies in relation to stressful events, societal relations to illness and the functioning of health services in relation to their effects on people. The author mentions about the bio-medical model and the social model of health. Health related quality of life also gets importance here. This book also deals with health needs and their assessment, demography and epidemiology. The need for health and the need for healthcare also get importance here. It also focuses on need for effective healthcare.

David R. Philips and Jola Verhasselt (ed.), *Health and Development*, Routledge, London and New York, 1994.

This book deals with health and development, the complex interrelationship between health and development. The writer focuses on the scale and nature of

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human activities, physical environment and biological environment, the impact of development policies on health is another important focus point of this book. This book deals importantly with changing environmental conditions and health, here socio-cultural environment gets importance. The writer also focuses on traditional medicine, its extent and potential for incorporation into modern national health systems. The health of women, beyond maternal and child health, healthcare services get much importance here. This book also deals with the poor third world, health and health are in areas that have yet to experience substantial development.

Byrd E. Oliver, *Health*, W. B. Saunders Company, Philadelphia and London, Toppan Company, Japan, 1966.

The writer focuses on health, health in marriage, health qualifications for marriage, menstruation. This book deals with family planning, pregnancy and prenatal care, childbirth etc. Disease and pregnancy get importance here. The hygiene of pregnancy, infant and child card, children's diseases and their prevention, immunizations in infancy and childhood etc all have been included in this book. The author also deals with health of the unborn baby, babies "at risk" etc many matters.

Emiko Ohnuki-Tierney, *Illness and Culture in Contemporary Japan*, Cambridge University Press, London, 1984.

This book focuses on illness and culture of Japan. The author focuses on anthropological approaches to healthcare systems. It has analyzed biomedicine as clearly failed to live up its almighty image, even in the Western societies where it originated. The author also focuses on public demand for alternative healthcare has placed considerable pressure on the medical profession. This

book also deals with doctors and out patients, pregnancy and childbirth, pregnancy sash etc.

Paul M. Insel and Walton T. Roth, *Care Concept in Health*, Mayfield Publishing Company, London, Toronto, 1998.

This book deals with the dynamic field of health, with new discoveries, advances, trends and theories. Sex and human body is one of the central themes of this book. The author gives much importance on sexuality which is more than just sexual behavior, this includes biological sex, gender, sexual anatomy and physiology, sexual functioning and practices, and social and sexual interactions with others. Hormones and the reproductive life cycle, pregnancy and childbirth, preconception care all have been analyzed here importantly. The author also focuses on the importance of prenatal care and nutritious diet, exercise, adequate rest, avoidance of drugs, and regular medical evaluation, all are essential to the health of both mother and baby. The healthcare system also has been discussed here.

Warren J. Karen (ed.) *Ecological Feminism*, Routledge, London and New York, 1994.

This book deals with "ecological feminism" that is an umbrella term which captures a variety of multicultural perspectives on the nature of the connections within social systems of domination between those human in subdominant or subordinate positions, particularly women, and the domination of nonhuman nature. The author also focuses on a variety of different eco-feminist positions, eco-feminist agree that there is an important link between the domination of women and the domination of nature, and that an understanding of one is allied

by an understanding of the other. This book also focuses on the eco-politics debate and the politics of nature, the limits of partiality etc.

In addition to the above mentioned literatures, we have reviewed some other literatures like *Bangladesh Demographic and Health Survey*,[3] *Gender Statistics of Banglaesh*[4] Statistical Yearbook of Bangladesh,[5] *Bangladesh Economic Review*[6] etc in order to get an idea about the population, healthcare and women empowerment in Bangladesh.

In the literatures reviewed above, there are some common important features. These are reproductive health, especially of mothers and children; the dearth of trained and motivated family planning workers of the grass-roots level, health centers and community maternity care, conceptualizing birthing care, maternal and childcare—normal versus complicated childbirth, place of delivery, resting after childbirth, family care etc. On regard to infant mortality the causes and conditions have been significantly highlighted by the authors. In pregnancy related deaths the authors discuss about the causes, gendering healthcare providers, family role etc. In health and healthcare in the third world countries the authors have tried to focus on the conditions, traditional and modern medicare facilities, practices of birthing care, family's role in birthing care, the role of *dai* in delivery, the necessary measures about maternal and child healthcare, mother-child deaths, quality of care, reproductive choice, cultural factors and fertility, demographic and socioeconomic situation, male involvement in the reproductive health, women's access to healthcare services in rural Bangladesh. The authors also highlight on birthing care, its origins, development and methods, beliefs and practices of childbirth, how power relations affect women's health seeking behavior during child delivery, women's perceptions and birthing care in home and beyond, easy and uneasiness of women during pregnancy. But access to reproductive healthcare from women

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empowerment point of view has not been dealt with which is the main subject matter of the present study. Yet the existing literatures will help me understood the subject matter theoretically and also will supply secondary materials for this study. Therefore, the present study is a new and pioneer one.

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Notes and References

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Chapter 3

Reproductive Healthcare: A Theoretical Understanding

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Chapter 3

Reproductive Healthcare: A Theoretical Understanding

3.1: Introduction

Perception of health and healthcare is as old as human civilization. All the populations of the world are concerned with health and it is gradually getting importance. Although health is one of the basic factors of human well-being but it is difficult to define. In the common sense of the term, "health" refers to the state of physical, mental and social well-being.[1]Several efforts have been made to define health which can broadly be divided into two main streams; one is a positive approach of health; and negative approach of health.[2]

Positive Approach: The positive approach views health as "the presence of certain qualities." The World Health Organization (WHO) in 1958 has defined health from a positive viewpoint which is stated as "Health is a state of complete physical, mental and social well-being and not merely absence of disease or infirmity, so that each citizen can lead a socially and economically productive life."[3]

Negative Approach: The negative approach of health refers to the "absence of disease and illness." According to this concept, a person is considered to be healthy when he/she does not suffer from a particular disease/illness. It may be mentioned here that disease and illness do not bear the same meaning. Disease is related to a biological malfunctioning, diagnosed by doctors, while illness refers both to the personal experience of disease and its wider social implications. Thus, the negative concept of health is closely associated with orthodox medicine with heavy focus on illness.[4]

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3.2: Dimensions of Health

There are four major dimensions of health according to the definitions of health. These are, physical, mental, social, and spiritual. On finer analysis a number of other dimensions can be identified, such as emotional, vocational, philosophical, cultural, socio-economic, environmental, educational, nutritional and also curative and preventive dimensions.[5]The four major dimensions of health are elaborated below:

Physical Dimension: This dimension is concerned with the perfect biological functioning of human physical systems and sub-systems, mentioning a physiological norm in harmony with each other and providing an optima sense of well-being to the individual concerned.

Mental Dimension: Mental dimension of health involves not only freedom from mental diseases but also includes a state of balance between an individual and the surrounding world, a harmony between the individual and his/her community in which he/she lives and a coexistence based on realities between the individual and his/her physical, social, economic and spiritual environment.

Social Dimension: Social dimension of health is based on the concept that a human being cannot achieve in isolation his or her full potential in any aspect of his or her life including health. He or she is a member of a family which again is a component of a community and society at large. Therefore, a man or woman's health is perceived from social point of view.

Spiritual Dimension: The spiritual dimension includes human integrity, adherence to ethics and principles an effort to understand the meaning and purpose of human existence, commitment to a higher being and certain belief and concepts which may or may not be amenable to ordinary reasoning.

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3.3: Determinants of Health

Generally, the context in which an individual lives in has of great importance on health status and quality of life. It is increasingly recognized that health is maintained and improved not only through the advancement and application of health science, but also through the efforts and intelligent lifestyle choices of the individual and society. According to the World Health Organization, the main determinants of health include the social and economic environment, the physical environment, and the person's individual characteristics and behaviors. More specifically, key factors that have been found to influence whether people are healthy or unhealthy include:

1. Income and social status;
2. Social support networks;
3. Education and literacy;
4. Employment/working conditions;
5. Social environments;
6. Physical environments;
7. Personal health practices and coping skills;
8. Healthy child development;
9. Biology and genetics;
10. Healthcare services.
11. Gender; and
12. Culture.

An increasing number of studies and reports from different organizations and contexts examine the linkages between health and different factors, including lifestyles, environments, healthcare organization, and health policy. The 1974 "Lalonde Report" from Canada, the Alameda Country Study in California and

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the series of "World Health Reports" of the World Health Organization focus on global health issues including access to healthcare and improving public health outcomes, especially in developing countries.

The concept of the 'health care' as distinct from medical care, emerged from the Lalonde Report from Canada. The report identified three interdependent fields as key determinants of an individual's health. These are:[7]

1. *Lifestyle*: the aggregation of personal decisions (i.e. over which the individual has contract) that can be said to contribute to, or cause, illness or death;
2. *Environment*: all matters related to health external to the human body and over which the individual has little or no control;
3. *Biomedical*: all aspects of health, physical and mental, developed within the human body as influenced by genetic make-up.

Focusing more on lifestyle issues and their relationships with functional health, data from the Alaneda country style suggested that people can improve their health via exercise, enough sleep, maintaining a healthy body weight, limiting alcohol use, and avoiding smoking. The ability to adapt and to self-manage has been suggested as core components of human health.

The environment is often cited as an important factor influencing the health status of individuals. This includes characteristics of the natural environment, the built environment, and the social environment. Factors such as clean water and air, adequate housing, and safe communities and roads all have been found to contribute to good health, especially the health of infants and children. Some studies have shown that a lack of neighborhood recreational spaces including natural environment leads to lower levels of personal satisfaction and higher levels of obesity, linked to lower overall health and well-being. This suggests the

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positive health benefits of natural space in urban neighborhoods should be taken into account in public policy and land use.

Genetics, or inherited traits from parents, also play a significant role in determining the health status of individuals and populations. This can encompass both the predisposition to certain diseases and health conditions as well as the habits and behaviors individuals develop through the lifestyle of their families. For example, genetics may play a role in the manner in which people cope with stress, mental, emotional or physical. However, the debate over the relative strength of genetics and other factors; interactions between genetics and environment may be of particular importance.

3.4: Stages of Reproductive Healthcare

It is known to all that special attention, care and facilities should be given to a pregnant woman because pregnancy is a dangerous period for women. In this stages of reproductive healthcare that a women receives during pregnancy, at the time of delivery, and soon after delivery is important for the survival and well-being of both mother and child. In this context, Bangladesh has committed to the Millennium Development Goals (MDGs) and has developed various policies and strategies for improving maternal and newborn health. Though all women of child bearing age are the beneficiaries of MCH services, the periods which are considered most important because of the special needs are: (1) antenatal (ANC) (2) intranatal (INC) and (3) postnatal (PONC) periods. The periods have been described below:

(1) Antenatal: Antenatal care is the care of the women during pregnancy. The primary aim of the continued care of women during pregnancy and child birth is to achieve at the end of pregnancy a healthy mother and a healthy child. In

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medical science, pregnancy period is divided into three stages. These are: (i) First three months; (ii) Middle three months; and (iii) Last three months.

(2) Intranatal: During or at the time of birth is called intrantal. All kinds of dangers and happenings are included in this stage. Antenatal supervision and intranatal care should form a continuum of planned responsibility. The basic principles of intranatal care that need to be carefully kept in mind are: (a) prevention of infection; (b) prevention of dehydration and ketosis of the mother; (c) relief of pain; (d) prevention of trauma; and (e) prevention of post-partum hemorrhage. Physicians, nurses, midwives or birth attendants should be trained to follow these principles. The "three cleans" i.e. (i) clean hands of the attendant; (ii) clean surface on which delivery is conducted; and (iii) clean equipment specially those used for cutting the cord of the baby or used for the woman can prevent most of the common infections contracted during delivery. The birth attendant should be thoroughly skilled in managing normal delivery without more than necessary trauma to the mother or the baby.

(3) Postnatal: Postnatal is the period beginning immediately after the birth of a child extending for about six weeks. The period is also known as postpartum period are less commonly puerperium. Biologically, it is the time after birth a time in which the mother's body, including hormone levels and womb size, return to pregnancy conditions. Loclia is post-partum vaginal discharge, containing blood mucus, and placental tissue. During the first stages of this period, the newborn also starts his or her adaptation to extra uterine life the most significant physiological transition and life giving until death.

3.5: Defining Reproductive Health

In the contemporary world, reproductive healthcare both of men and women is gradually getting importance. It is recognized by all that population and

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development are intertwined. From this spirit, human being is moving toward ensuring standard reproductive healthcare. On September 13 1994, in Cairo, after nine days of intense debate the International Conference on Population and Development (ICPD) adopted a wide ranging 20-year action plan that delegates and commentators hailed as opening a "new era in population."[8] The ICPD set the goal of ensuring universal voluntary access to a full range of reproductive healthcare information and services by 2015.[9] Delegates also agreed that sexual and reproductive health is a human right, part of the general right to health.

Reproductive health is a holistic concept, a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have capability to reproduce and the freedom to decide it, when and how often to do so. "Sexual and reproductive health encompasses a woman's ability to exercise her right to control what happens to her body; to make choices about whether, when and with whom to have intimate relationship, and if and when to have children; to protect herself from diseases associated with reproduction; and to have informed access to health services. As a prerequisite for sexual and reproductive health, quality health services must exist, and women and girls must live in environments that enable them to seek services and practice healthy behaviors.[10]

Development Alternatives with Women for a New Era (DAWN) defines reproductive health in the following way:[11]

> Reproductive health as inextricably intertwined with women's human rights. Therefore, DAWN's framework for women's reproductive rights and health incorporates attention to women's economically productive and cultural rules in addition to their biological

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> reproductive functions. And in the biological context, DAWN's definition of reproductive health services includes not only access to contraceptive information and methods and legal abortion, but also STD and cancer prevention, prenatal care and mental health services, all within the context of comprehensive preventive health services. A further element of the DAWN proactive on reproductive health is respect for traditional health knowledge, much of which is gradually being destroyed by imposed medical technologies.

The key to reproductive health is making motherhood safer via (1) access to family planning to reduce unintended pregnancies and to space intended pregnancies; (2) skilled care for all pregnancies and births; (3) timely obstetric care for complications during childbirth; and (4) skilled care for women and babies after delivery.[12] The more likely it is that a woman will give birth with a skilled attendant present, the better outcome is likely to be. Poorer women and poorer countries with lower proportions of attended births have higher rates of maternal mortality and morbidity. A woman may choose a traditional rather than a skilled birth attendant because the former provides a range of services before and after delivery, and because she is more familiar with the woman and her culture. Providing skilled birth attendants who have a cultural connections with the women they serve, as well as effective emergency and obstetric care backup and referral, which are also culturally acceptable, is a challenging for reproductive health services.

Reproductive health and healthcare largely depends on reproductive rights a society provides its women members. Reproductive rights derive from the recognition of the basic right of all individuals and couples to make decisions about reproduction free from discrimination, coercion or violence. They include the right to the highest standard of health and the right to determine the number,

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timing and spacing of children. They comprise the right to safe child-bearing, and the right of all individuals to protect themselves from HIV and other sexual transmitted infections.[13]

Within the framework of the World Health Organization's (WHO) definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health, or sexual health/hygiene, addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do. Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of birth control of their choice; and the right of access to appropriate healthcare services of sexual and reproductive medicine that will enable women go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

Sexual Health

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.[14]For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

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Childbearing and Health

Early childbearing and other behaviors can have health risks for women and their infants. Waiting until a woman is at least 18 years old before trying to have children improves maternal and child health. If an additional child in desired, it is considered healthier for mother, as well as for the succeeding child, to wait at least 2 years after previous birth before attempting to conceive. After a miscarriage or abortion, it is healthier to wait at least 6 months.[15]

The WHO estimates that each year 3,58,000 women die due to complications related to pregnancy and childbirth; 99% of these deaths occur within the most disadvantaged population groups living in the poorest countries of the world.[16] Most of these deaths can be avoided with improving women's access to quality care from a skilled birth attendant before, during and after pregnancy and childbirth.

Reproductive Health and Abortion

An article from the World Health Organization calls safe, legal abortion, "a fundamental right of women, irrespective of where they live" and unsafe abortion a silent pandemic. The article states "ending the silent pandemic of unsafe abortion is an urgent public health and human's rights imperative."[17]

WHO's Global Strategy on Reproductive Health, adopted by the World Health Assembly in May 2004, and noted: As a preventable cause of maternal mortality and morbidity, unsafe abortion must be dealt with as part of the MDG on improving maternal health and other international development goals and targets."[18] The WHO's development and Research Training in Human Reproduction (HRP), whose research concerns people's sexual and reproductive health and lives, has an overall strategy to combat unsafe abortion that comprises four interrelated activities:

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1. to collect, synthesize and generate scientifically sound evidence on unsafe abortion prevalence and practices;
2. to develop improved technologies and implement interventions to make abortion safer:
3. to translate evidence into norms, tools and guidelines; and
4. to assist in the development of programmes and policies that reduce unsafe abortion and improve access to safe abortion and high quality post-abortion care.

3.6: Reproductive Medicine

Reproductive medicine is a branch of medicine that deals with prevention, diagnosis and management of reproductive problems; goals include improving or maintaining reproductive health and allowing people to have children at a time of their choosing. It is founded on knowledge of reproductive analogy, physiology, and endocrinology, and incorporates relevant aspects of molecular biology, biochemistry and pathology.[19]

Scope: Reproductive medicine addresses issues of sexual education, puberty, family planning, birth control, infertility, reproductive system disease (including sexually transmitted diseases) and sexual dysfunction. In women, reproductive medicine also covers menstruation ovulation, pregnancy and menopause, as well as gynecologic disorders that affect fertility. The field cooperates with and overlaps mainly with reproductive endocrinology and infertility, sexual degree with gynecology, obstetrics, urology, genitourinary medicine, medical endocrinology, pediatric endocrinology, genetics, and psychiatry.

Methods: In the assessment of patients imaging techniques, laboratory methods and reproductive surgery may be needed. Treatment methods include

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counseling, pharmacology (e.g. fertility medication), surgery and other methods. In vitro fertilization has evolved as a major treatment modality that has enabled the study of the embryo prior to implantation.

Education and Training: Specialists in reproductive medicine usually undergo training in obstetrics and gynecology followed by training in reproductive medicine specialists in contraception, other methods of training are possible. Specialists tend to be organized in specially organizations such as American Society of Reproductive Medicine (ASRM) and European Society of Human Reproduction and Embryology (ESHRE).

Anamnesis: The anamnesis or medical history taking of issues related to reproductive or sexual medicine may be inhabited by a reluctance of the patient to disclose intimate or uncomfortable information. Even if such an issue in on the patient's mind, he or she often doesn't start taking about such an issues without the physician initiating the subject by a specific question about sexual or reproductive health. Some familiarity with the doctor generally makes it easier for patients to talk about insinuate issues such as sexual subjects, but for some patients, a very high degree of familiarity may make the patient reluctant to reveal such intimate issues. When visiting a health provider about sexual issues, having both partners of a couple present is often necessary, and is typically a good thing, but may also prevent the disclosure of certain subjects, and, according to one report, increases the stress level.

3.7: Reproductive Rights

Reproductive rights are legal rights and freedoms relating to reproduction and reproductive health. The World Health Organization defines reproduction rights as follows:[20]

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> Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.

Reproductive rights may include some or all of the following: the right to legal or safe abortion, the right to birth control, the right to access quality reproductive healthcare, and the right to education and access in order to make free and informed reproductive choices[21]. Reproductive rights may also include the right to receive education about contraception and sexually transmitted infections, and freedom from coerced sterilization, abortion, and contraception, and protection from gender-based practices such as female genital mutilation (FGM) and male genital mutilation (MGM).

Reproductive rights began to develop as a subset of human rights at the United Nation's 1968 International Conference on Human rights. The resulting non binding Proclamation of Teheran was the first international document to recognize one of these rights when it stated "parents have a basic human right to determine freely and responsibly the number and the spacing of their children."[22] States, though, have been slow in incorporating these rights in internationally legally binding instruments. Thus, while some of these might have already been mentioned only in non-binding recommendations and, therefore, have at best the status of law in international law, while a further group is yet to be accepted by the international community and therefore remain at the level of advocacy. According to pro-choice activist Laura Knudsen, issues related to reproductive

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rights are some of the most vigorously contested rights issues worldwide, regardless of the population's socioeconomic level, religion or culture.[23]

3.8: Human Rights

Since most existing legally binding international human rights instruments do not explicitly mention sexual and reproductive rights, a broad coalition of NGOs, civil servants, and experts working in international organization have been promoting a reinterpretation of those instruments to link the realization of the already internationally recognized human rights with the realization at reproductive rights.

Amnesty International has argued that the realization of reproductive rights is linked with the realization of a series of recognized human rights, including the right to health, the right to freedom from discrimination, the right to privacy, and the right not to be subjected to torture or ill-treatment.[24]However, not all states have accepted the inclusion of reproductive rights in the body of internationally recognized human rights. At the Cairo Conference, several states made formal reservation either to the concept of reproductive rights or to its specific content.

3.9 (a): Rights of Women

The United Nations Population Fund (UNFPA) and the World Health Organization (WHO) advocate for reproductive rights with a primary emphasis on women's rights. In this respect the UN and WHO focus on a range of issues from access to family planning services, sex education, menopause, and the reduction of obstetric fistula to the relationship between reproductive health and economic status.[25]

Attempts have been made to analyze the socioeconomic conditions that affect the realization of a woman's reproductive rights of under study. The term

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reproductive justice has been used to describe these broader social and economic issues. Proponents of reproductive justice argue that while the right to legalize abortion and contraception applies to everyone, these choices are only meaningful to those with resources and that there is a growing gap between access and affordability.

3.9 (b): Men's Rights

Men's reproductive rights have been claimed by various organizations, both for issues of reproductive health, and other rights related to sexual reproduction. Three international issues in men's reproductive health are sexually transmitted diseases, cancer and exposure to toxin.

Recently men's reproductive right with regards to paternity has become subject of debate in the U.S. The term "male abortion" was coined by Malaria, a South Carolina attorneg, in a 1998 article.[26]The theory begins with the premise that when a woman becomes pregnant she has the option of abortion, adoption, or parenthood; it argues in the context of legally recognized gender equality, that in the earliest stages, of pregnancy the putative (alleged) fathered should have the right to relinquish all future parental rights and financial responsibility, leaving the informed mother with the same three options. This concept has been supported by a former president of the feminist organization National Organization for Women, attorney Karen DeCrow.[27]

In 2006, the National Center for Men brought a case in the US, Dubay v. Wells (dubbed by some "Roe v. Wade for men"), that argued that in the event of an unplanned pregnancy, when an unmarried woman informs a man that she is pregnant by him, he should have an opportunity to give up all paternity rights and responsibilities. Supporters argue that this would allow the women time to make on informed decision and give men the same reproductive rights as

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women. In its dismissal of the case, the U.S. Court of Appeals (Sixth Circuit) stated that "The Fourteenth Amendment does not deny to the state the power to treat different classes of persons in different ways."[28]

3.10: Reproductive Justice

Reproductive justice is a concept linking reproductive health with social justice. The term emerged from the work of reproductive health organizations for women of color in the United States in the 1990s.[29] Proponents of the concept of reproductive justice aim to recognize that women's reproductive health is connected to and affected by conditions in their lives that are shaped by their socioeconomic status, human rights violations, race, sexuality and nationality. Proponents argue that women cannot leave full control over their reproductive lives unless issues such as socioeconomic disadvantage, racial discrimination, inequalities in wealth and power, and differential access to resources and services are addressed. The grassroots organization Asian Communities for Reproductive Justice defines reproductive justice as follows: "We believe reproductive justice is the complete physical, mental, spiritual, political, economic and social wellbeing of women and girls, and will be achieved when women and girls have the economic, social and political power and resources to make health decision about our bodies, sexuality and reproduction for ourselves, our families and our communities in all areas of our lives.[30]

3.11: Reproduction and Reproductive Systems

In a general sense, reproduction is one of the most important concepts in biology. It means making a copy a likeness, and thereby providing for the continued existence of species. Although reproduction is often considered solely in terms of the production of offspring in animals and plants, generally meaning has far greater significance to living organisms.[31] To appreciate this fact, the

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origin of life and the evolution of organisms must be considered. One of the first characteristics of life that emerged in primeval times must have been the ability of some primitive chemical system to make copies of it.

At its lowest level, therefore, reproduction is chemical replication. An evolution progressed, cells of successively higher levels of complexity must have arisen, and it was absolutely essential that they had the ability to make likeness of themselves. In unicellular organisms, the ability of one cell to reproduce itself means the reproduction of a new individual; in multicellular organisms, however, it means growth and regeneration. Multicellular organisms also reproduce in the strict sense of the term that is, they make copies of themselves in the form of offspring – but they do so in a variety of ways, many involving complex organs and elaborate hormonal mechanisms.

The Human Reproductive System

Man belongs to that group of mammals characterized by the bearing of live offspring that have attained considerable development within the uterus, or womb. Provided all organs are present, normally contracted, and functioning properly, the essential features of human reproduction are: (1) liberation of an egg from the ovary of the right time in the reproduction cycle; (2) internal fertilization by spermatozoa (sperm or male sex cells) of the ovum in the uterine tube; (3) transport of the fertilized ovum along the uterine tube to the uterus; (4) implantation of the blastocyst, the early mloryo that develops from the fertilized ovum, in the wall of the uterine; (5) formation of a placenta and maintenance of the intra-uterine existence of the unborn child; (6) birth of the child and expulsion of the placenta; and (7) suckling and care of the child with an eventual return of the maternal organs virtually to their original state.

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A new individual is created when the elements of a potent sperm merge with those of a fertile ovum, or egg. Before this union both the spermatozoon (sperm) and the ovum have migrated for considerable distances in order to achieve their union. A number of actively motile spermatozoa are deposited in the vagina, pass through the uterus, and invade the uterine (fallopian) tube, where they surround the ovum. The ovum has arrived there after extrusion from its follicle, or capsule, in the ovary. After it enters the tube, the ovum loses its outer layer of cells as a result of action by substances in the spermatozoon and from the lining of the tubal wall. Loss of the outer layer of the ovum allows a number of spermatozoon to penetrate the egg's surface. Only one spermatozoon however, normally becomes the fertilizing organism. Once it has entered the substance of the ovum the nuclear head of this spermatozoon separates from its tail. The tail gradually disappears, but the head with its nucleus survives. As it travels toward the nucleus of the ovum, the head enlarges and becomes the male pronucleus. The two pronuclei meet in the centre of the ovum, where there threadlike chromatin material organizes into chromosomes.

Originally the female nucleus has 44 autosomes (chromosomes other than sex chromosomes) and two (x, x) sex chromosomes. Before fertilization a type of cell division called a reduction division brings the number of chromosomes in the female pronucleus down to 23, including one x chromosome. The male gamete or sex cell, also has 44 autosomes and two (x, y) sex chromosomes. As a result of a reducing division occurring before fertilization, it too, has 23 chromosomes including either an x or a y sex chromosome at the time that it merges with the female pronucleus.[32]

After the chromosomes merge and divide in a process termed mitosis, the fertilized ovum, or zygote, as it is now called divides into two equal sized daughter cells. The mitotic division gives each daughter cell 44 autosomes, half

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of which are of maternal and half of paternal origin. Each daughter cell also has either two x chromosomes, making the new individual a female, or an x and a y chromosome, making it a male. The sex of the daughter cells is determined, therefore, by the sex chromosome from the male parent.

Fertilization occurs in the uterine tube. How long the zygote remains in the tube is unknown, but it probably reaches the uterine cavity about 72 hours after fertilization. It is nourished during its passage by the secretions from the mucous membrane living the tube. By the time it reaches the uterus it has become a mulberry like solid mass called a morula. A morula is composed of 60 or more cells. As the number of cells in a morula increases the zygote forms a hollow bubble like structure, the blastocyst. The blastocyst, nurtured by the uterine secretions, floats free in the uterine cavity for a short time and then in implanted in the uterine lining. Normally the implantation of the blastocyst occurs in the upper portion of the uterine below.

3.12: Symptoms and Signs: Biological Tests

Outward early indications of pregnancy are missed menstrual periods, morning nausea, and fullness and tenderness of the breasts; but the positive and certain signs of gestation are the sounds of the fetal heartbeat, which are audible with a stethoscope between the 16^{th} and the 20^{th} week of pregnancy; x-ray views of the fetal skeleton, which can be observed by the 14^{th} or the 16^{th} week; and fetal movements which usually occur by the 18^{th} to the 20^{th} week at pregnancy, x-ray examinations generally are avoided, however, because of their potential hazard to the fetus.[33]

Persons who note their body temperature upon awakening, as many women do who wish to know when they are ovulating, may observe continued elevation of the temperature curve well beyond the time of the missed period; this is strongly

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suggestive of pregnancy. During the early months of pregnancy, women may notice that they urinate frequently because of pressure of the enlarging uterus on the bladder; that they feel tired and drowsy; dislike foods that were previously palatable; have a sense of pelvic heaviness; are subject to vomiting and to pulling pains in the sides of the abdomen, as the growing uterus stretches the round ligaments that help support it singly or together. Most of these symptoms subside as pregnancy progresses. The signs and symptoms of pregnancy are so definite by the 12th week that the diagnosis is seldom a problem.

Biological tests for pregnancy depend upon the production by the placenta of chorionic gonadotropin, an ovary stimulating hormone. In practice, the tests have accuracy at about 95 percent, although false negative tests may run as high as 20 percent in a series of cases.[34]False negative reports are frequently obtained during late pregnancy when the secretion of chorionic gonadotropin normally decreases. The possibility not only of false negative but also at false positive tests makes the testes at best probable rather than absolute evidence of the presence or absence of pregnancy. Chorionic gonadotropin in a woman's blood or urine indicates only that she is harbouring living placental tissue. It does not tell anything about the condition of the fetus. In fact, the greatest production of chorionic gonadotropin occurs in certain placental abnormalities and disorders that can develop in the absence of a fetus.

Several signs noted by the physician during an explanation suggest that a patient may be in the early months of pregnancy. Darkening of the areola of the breast (the small, coloured ring around the nipple) and prominence of the sebaceous glands around the nipple (Montgomery's glands); purplish-red discoloration of the vulvar, vaginal, and cervical tissues; softening of the cervix and of the lower part of the uterus and of course, enlargement and softening of the uterus itself are suggestive, but not necessary proof of pregnancy.

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3.13: Pregnancy and Complications

Pregnancy is a natural process which results from the union of the ovum from the woman and the sperm from the man. There is a popular belief that the woman's 'womb' plays a role in determining the sex of the baby. In fact, the type of sperms is the deciding factor, not the womb of woman.[35]

All women are considered to be 'at risk' of developing complications when they become pregnant. These complications may develop at any time during pregnancy, delivery or even in a period of up to six weeks following childbirth. Most complications which arise due to malnutrition can be prevented, but other problems cannot even be predicted accurately, or possible to prevent many of the complications arising from pregnancy and childbirth.

Many women who survive complications suffer disability and pain for the rest of their lives. In fact, women who die from pregnancy related causes are mainly from obstructed labor abortion related complications, post-partum bleeding, puerperal sepsis and toxemia of pregnancy. It is estimated that against each death, at least 30 women suffer with complications, which are painful and lifelong. 'Fistula' is such a condition. It results constant leaking of urine/stool beyond the woman's control making her life miserable and her company undesirable for many people. 'Prolapse' is another condition that involves displacement of the uterus, resulting in pain, bleeding discharge and infection.

3.14 (a): Risk Factors

The risk of dying is higher among girls who become pregnant when they are less than 20 years and among women who become pregnant before their youngest child is 2 years old have more than four pregnancies or become pregnant after the age of 35 years or malnourished.[36]

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3.14 (b): Special Care

Access to antenatal, natal and postnatal care with focused attention on malnutrition, skilled birth attendance and, more importantly, emergency obstetric care, greatly reduces the risk of dying during pregnancy or delivery. The family has an important role to play in ensuring that a woman eats and taka enough rest during pregnancy and following delivery. They have the responsibility to ensure that she makes use of available healthcare service. The family has responsibility to prepare for the birth by keeping ready a new unused blade, thread, soap, clean cloth as well as clothes for the newborn baby and some cash money to need any emergency.

Antenatal and postnatal check-ups by doctors on trained health and family planning workers provide the woman and her family with important information related to pregnancy and childbirth food supplements like iron and vitamin A, TI immunization and the detection of warning signs or complications. Availing the services of trained birth attendants prevents practices that are harmful for both the mother and the newborn. The trained attendant is able to detect signs of complications, which include services of emergency obstetric is essential.

3.14 (c): Danger Sings

When a woman develops dangerous obstetric complications, she urgently requires emergency obstetric care. The danger signs (that means a woman has develop life threatening complications) are the following: [37]

1. Bleeding from the birth canal before delivery or excessive bleeding following delivery;
2. Severe headache and blurring of vision;
3. Swollen hands and feet;

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4. Severe vomiting;
5. Convulsion;
6. High fever;
7. Labor prolonging from sun rise to sun set (for more than 12 hours);
8. Smelly vaginal discharge;
9. Any part of the body showing except the head.

The development of any of these sings is the signal for the family to take the woman to the nearest appropriate health facility without delay. The husband and family need to prepare for emergency ahead of time by putting away some money in advance, by identifying transport to take the woman to the health facility, and by finding out, beforehand, where to go if complications develop. Communities also have an important role to play a head of and during an emergency. Communities can help with arranging transportation, funds creative and collecting blood donors and provide other types of support.

3.14 (d): Danger Signs of Pregnancy and Child Birth

Maternal death in Bangladesh is very high. For giving birth to 1000 living body there is still loss of about four mothers. Every day in Bangladesh a huge number of mothers are dying due to complications of pregnancy and childbirth. The causes of maternal deaths are identified and most of which are preventable. The major causes of mother's death are universal to all developing countries as well as in the world. Mothers are dying due to excessive blood loss during pregnancy or delivery or after delivery. They are also dying due to eclampsia, sepsis (infection), obstructed labor and unsafe abortion. But all these major problems of death can be averted if the community people aware about danger signs of pregnancy and delivery which give warning for the major problems and

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emergency measure can be taken accordingly. Mothers' lives would be saved if life saving emergency obstetrics care were available and accessible for them at their need.

3.15: Reproductive Healthcare: Scenario of Bangladesh

Ensuring primary healthcare for the citizen of Bangladesh has been a constitutionally recognized obligation for the state authority. Conditions of healthcare of the people in such a densely populated poor country are very low. Particularly, all indices of mother and child healthcare in the rural areas demonstrate the country's very low and marginal reproductive healthcare scenario. Bangladesh has never seen any of its health policies implemented since independence in 1971. A policy drawn up in 1990 never got the green light and was eventually cancelled. Although another policy was finalized and accepted in 2000, it never saw implementation due to a changed government soon after in 2001. The current draft is based on that of 2000.[38]

Bangladesh government is the main healthcare provider which plays significant roles in healthcare sector. Other healthcare providers like donor agencies, NGO's and individual work under the control and direction of the government. Therefore, government's measures exert vital impact on people's healthcare. In order to improve people's healthcare conditions each government either formulates a new national health policy on follows the old one. In support of the national health policy, the government simultaneously formulates the national health policy, national food and nutrition policy, national drug policy, national policy on HIV/AIDS and STD related issues.[39]

Apart from certain policies on healthcare and population, the government has proposed and adopted MGDs. In the "Millennium Development Goals: Bangladesh" (MDGs), there are mainly 8 goals which are:[40]

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Goal 1: Eradicate extreme poverty and hunger;

Goal 2: Achieve universal primary education;

Goal 3: Promote gender equality and empower women;

Goal 4: Reduce child mortality;

Goal 5: Improve maternal health;

Goal 6: Combat HIV/AIDS, malaria and other diseases;

Goal 7: Ensure environmental sustainability; and

Goal 8: Develop a global partnership for development.

In addition the government attempts to provide necessary healthcare services through reducing poverty. For this purpose, PRSP has been framed and adopted. Poverty Reduction Strategy Papers (PRSP) are prepared by the members countries through a participatory process involving domestic stakeholders as well as external development partners, including the World Bank (WB) and International Monetary Fund (IMF). Updated every three years with annual progress reports, PRSPs describe the country's macroeconomic, structural and social policies and programs over a three year or longer horizon to promote broad-based growth and reduce poverty, as well as associated external financing needs and major sources of financing.[41]

The poor health conditions in Bangladesh are attributed by the lack of healthcare and services provisions by the government. The total expenditure on healthcare as a percentage of its GDP was only 3.35% in 2009, according to a World Bank report published in 2010.[42] The number of hospital beds per 10,000 population is 4.[43] The general government expenditure on healthcare as a percentage of total government expenditure was only 7.9% as of 2009 and the citizens pay most of

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their health care bills as the out-of-pocket expenditure as a percentage of private expenditure on health is 96.5%.[44]

Malnutrition is one of the most serious health problems affecting children and their mothers in Bangladesh. Undernourished mothers face greater risks during pregnancy and childbirth, and their children set off on a weaker development path, both physically and mentally. In Bangladesh, 26% of the populations are undernourished[45] and 46% of the children suffer from moderate to severe underweight problem.[46] 43% of children under 5 years old are stunted. One in five preschool age children are vitamin A deficient and one in two are anemic.[47]Undernourished children have lower resistance to infection and are more likely to die from common childhood ailments as diarrheal diseases and respiratory infections. Malnutrition prevents individuals and even the whole country from achieving full potential, and is closely related with survival, poverty and development. In fact, underweight is being used to track the progress of Bangladesh towards the Millennium Development Goal (MDG 1) for poverty reduction, and nutrition is closely linked with the MDGs for child survival (MDG 4) and maternal health (MDH 5).[47]

According to Bangladesh Demographic and Health Survey 2007, 60 percent of women with a birth in the five years preceding the survey received antenatal care at least once from any provider; 52 percent received care from a medically trained provider, that is, a qualified doctor, nurse, midwife, paramedic, family welfare visitor (FWV), community skilled birth attendant (CSBA), medical assistant (MA), or sub assistant community medical officer (SACMO). Antenatal care from a medically trained provider has increased from 49 percent in 2004 to 52 percent at present.[48]

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Proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that may cause the death or serious illness of the mother and the baby. *The 2007 BDHS* asked women the place of birth of all children born in the five years before the survey. According to the survey, 15 percent of births in Bangladesh take place at a health facility, about half in the public sector and half in the private/NGO sector.[49]

Postnatal care is a crucial component of safe motherhood. Postnatal checkups provide an opportunity to assess and treat delivery complications and to counsel mothers on how to care for themselves and their children.[50] *The 2007 BDHS* assessed the utilization of postnatal care for the most recent live birth among women who had delivered a child in the five years preceding the survey. In the five years preceding the survey about 30 percent of women received postnatal care following their last birth. One in five women (21) overall, age 15-49 who had a birth in five years preceding the survey received postnatal care from a medically trained provider following their most recent live birth. Approximately 17 percent of mothers received postnatal care from a qualified doctor, 4 percent of mothers received care from a nurse, midwife, paramedic, and 9 percent received care from non-medically trained providers like TBAs, HAS, and FWAs.[51]

3.16: Conclusion

Human reproduction in real sense is a biological phenomenon, and it's any kind of care is also very much biological care provided by medical practioneers. Recently this traditional view is rapidly changing. Reproductive health and healthcare is perceived from many dimensions. As women's reproductive healthcare is no longer confined to biological domain rather it has been involved

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with social, psychological, economic, political environmental and other factors by which reproductive healthcare is influenced and determined. Particularly, women's reproductive healthcare is very much dependent on availability of the care and services and the distribution system of the care in a society. Therefore, women's reproductive healthcare should be perceived from socio-psychological basis. The present study has followed this path in order to understand women's reproductive health and healthcare.

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Chapter 4

Demographic and Geo-Political Structure of the Study Area

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Chapter 4

Demographic and Geo-Political Structure of the Study Area

4.1: Introduction

The present study has selected a village which is called *Hazipur*, located in *Pakutia* Union under *Saturia* Thana in *Manikgonj* District. It is a typical village of Bangladesh from the considerations of location, population, economy, infrastructure, socio-demographic characteristics of the population, health and healthcare system, conditions of women, and so on. It is assumed that *Hazipur* represents most of the villages of Bangladesh and what is true about *Hazipur* is likely to be true about other villages of the country. In this context, this chapter has attempted to describe the demographical and geo-political characteristics of the village under study.

4.2: Geographical Location

Geo-physically, the village is located in a low land area. Total area of *Hazipur* is about 5.5 square kilometer which indicates that the village is big in size. It is surrounded by corn fields. At the eastern side of the village there is *Charpara*, western side *Barra* and *Naogaon*, southern side *Kaunmara,* northern side *Baliati*. The village is fragmented into some *paras: Moddyapara, Baganbari, Miabari, Fakirbari, Uttarpara.* Of those, *Moddhya* (central) *para* is the richest and most dominant in every spheres of life. Once *Baganbari* area was deserted and it was the *bagan* (garden) of the *Jamidar* of *Saturia*. The village is located about 4 kilometers away from *Saturia Sadar.*

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Photograph-4.1: A Natural View of *Hazipur* Village from Outside

4.3: Population

The total population of the village is 4,128 which includes both male (2,097) and female (2,031). Male-female percentage of the population is 50.8 and 49.2 respectively. Total number of household is 860. Most of the inhabitants are Muslim and a few Hindus. The age distribution of the villagers has been shown in Table-4.1 and age distribution of the respondents in Table-4.2. Marital ages of the respondents have been shown in Table-4.3.

Table-4.1: Distribution of Age of the Villagers of *Hazipur*

Age	Total	Percentage (%)
0-10	628	15.21
11-20	607	14.70
21-30	591	14.32
30-40	583	14.12
41-50	574	13.91
51-60	556	13.47
61+	589	14.27
Total	4,128	100%

Source: Field data 2012

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Table-4.1 presents the ages of the villagers of *Hazipur*. The highest number (15.21) of the population belongs to 0-10 age group. The rest of the population belongs to almost equal percentage of age groups.

Table-4.2: Age Distribution of the Respondents

Age	Total	Percentage (%)
+20	47	14.42
21-30	83	25.46
31-40	79	24.23
41-50	67	20.55
51+	50	15.34
Total	326	100%

Source: Field data 2012

Table-4.2 demonstrates the age distribution of the respondents of the study. It shows that most of the respondents belong to 21-30, 31-40 and 41-50 and their percentages are25.46, 24.2 and 20.55 respectively.

Table-4.3: Marital Ages of the Respondents

Marital Age	Total	Percentage (%)
+12	43	9.29
13-16	132	28.51
17-20	164	35.42
25-28	28	6.05
29+	7	1.5
Total	463	100%

Source: Field data 2012

*Total number of married (first marriage) women in *Hazipur* is 463.

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Table 4.3 presents the marital ages of the respondents of the study. It has been found that most of the respondents belong to 13-16 and 17-20 and their percentages are 28.51 and 35.42 respectively. It indicates that most of the women get married in the rural area during 13-20 ages.

Under 5 age population of the village is 418 (9.98%). Total number of voters is 2,560. Total number of women given birth at least once is 398. Rate of literacy in women is 51.84 and men 56.28%. Most of the women are engaged in household except a few service holders in primary, high school, NGOs and garments workers.

4.4: Economy

The mode of production of *Hazipur* is predominantly agricultural. Most of the people are employed in agriculture. The land of the village is fertile and arable. Various types of crops are produced in the village. Agricultural products are produced mainly for own consumption and commercialization of agriculture in the village is almost unknown. Share cropping and tenant system is prevailing in the village. Some people are engaged in service, day labor, mason, wood maker, business, self-employment and women are mostly in house wives. The village is stratified from the viewpoint of resource possession: most of the households are poor and marginal except a few ones. Some people work in Dhaka city, and most of them reside in the village. There is a poultry farm in the village. No other industrial establishment is located in the village. Inhabitants of the village are mostly poor in terms of per capita income.

The houses of *Hazipur* are mostly made of mud and tin and a few brick made. Most of the households are electrified but it is not used in any commercial purpose, because there is no small industry in the village except a poultry farm.

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The village is physically divided into some *paras* but such a division is not significantly related with women's reproductive healthcare.

4.5: Educational Institutions

There is a government primary school in the village which was established in 1950. There are two NGOs schools in the village operated for the children of the poor people. Two *moqtabs* (religious learning institution) are run under the fabric of two *mosques*. The children of all economic backgrounds take part in the *moqtab*. The students go to *Baliati* High School and *Saturia* High School for secondary and higher secondary education, and to *Saturia* College for college education.

Table-4.4: Educational Status of the Villagers of *Hazipur*

Educational Status	Total	Percentage (%)
Illiterate	1,895	45.90
Primary	1,264	30.62
Secondary	432	10.47
Higher Secondary	313	7.59
Degree	208	5.03
Masters and Above	16	0.39
Total	4,128	100%

Source: Field data 2012

Table-4.4 presents the educational status of the villagers of *Hazipur*. The data shows that most of the (45.90) people belong to illiterate education group. Next to this majority group belongs to primary education group (30.62%).

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Table-4.5: Educational Status of the Respondents

Educational Status	Total	Percentage (%)
Illiterate	184	56.44
Primary	73	22.39
Secondary	41	12.58
Higher Secondary	18	5.52
Degree	8	2.45
Masters and Above	2	0.61
Total	326	100

Source: Field data 2012

Table- 4.5 shows the educational status of the respondents of the study. It has been found that most of the (56.44%) respondents belong to illiterate education group. Next majority group of the respondents (22.39%) belong to primary education group. Average rate of literacy of both male and female in the village is 54.06%; male 56.28% and female 51.84%.

Photograph-4.2: The Government Primary School of *Hazipur* Village

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Photograph-4.3: *Baliati* High School Where the Children of *Hazipur* Go for High School Education

4.6: Transport and Communication

Hazipur is located about 4 kilometers northern side from *Saturia sadar*. The village is connected with *Saturia sadar* by *Saturia-Nagorpur* road from eastern side and a *kancha* road from south-western side. Inside the village, there are about 2 kilometers brick-made road and about 3 kilometer *kancha* road. Internal communication system in the village is not good enough and the inhabitants are to depend on *kancha* road and *payee hata path* (mud made road for walking) for that. Radio and television are frequently used in many families of the village and satellite connection of television has been found in the village. Some families are the subscribers of some daily newspapers. Mobile phone of various companies is available in the village. Therefore, the mass media communication has been covered the village as well as outside of the world. During the rainy season,

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spatial mobility of the villagers is confined and they have to mostly depend on boat.

4.7: Social Life and Social Relations

Awareness of cooperation of the villagers is a dominant feature of its society. As a result, the youth people have built a club named '*Hazipur* Youth Club'. To perform some social welfare activities are the main purposes of the club. Of course, this club has been established by the instigation, co-operation and leadership of some rich men in order to maintain their domination. A person whose name is Ayub Khan has dominated the village by his own charismatic way. There are some *gosthis* (clan) in the village. The villagers again are sub divided into *samaj*. But conflicts among these social groups hardy take place. There are some NGOs working in the village. Mostly the poor people of the village are the main participants of these NGOs. A number of poor women are the members of the NOGs.

4.8: Religion and Religious Life

Most of the villagers are Muslim except a very few Hindus reside in *Bangabari para* of the village. But the Hindus and Muslims coexist and are living very much harmoniously and peacefully. As a result, their religious life is not harmful to enjoy and perform daily activities. Both the religious groups respect each other. There are three mosques and a temple in the village. A mosque located near the home of former UP chairman is the most well off, popular and respected by the devotees. Most of the Muslim villagers gather in the mosques every Friday for *Jumma* prayer, and a few devotees gather five times for regular prayer. There is an *Eid-gah* located in the western side of the village. The *Eid-gah* committee has been consisted of the influential and pious persons of the

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villagers such as the chairman and members of the Union Council/*Parishad*. Same is true in the case of Mosque Committees. All the Muslims of the village belong to Sunni sect. There is a household of a *pir* (religious mystic) in the village. But the villagers of *Hazipur* are not the devotees of the *pir* rather the devotees are mostly outsiders. Regarding Hindus, they perform their religious activities in a temple located in *Baganbari* of the village. But the temple is very old and in the state of being worn out. From religious point of view, the village is not a conservative village rather religious tolerance and peaceful coexistence and harmonious situation have signified the religious life of the villagers. Distribution of religions of the respondents has been shown in Table-4.6.

Table-4.6: Distribution of Religions of the Respondents

Religion	Percentage (%)
Muslim	91.59
Hindu	8.41
Total	100

Source: Field data 2012

Table-4.6 presents the distribution of religions of the respondents of the study. It shows that most of the (91.59%) respondents are Muslims and Hindus are 8.41 percent. These figures present almost the national figure of the country.

4.9: Health and Healthcare

Health and healthcare condition of the villagers is not good enough to compare with other villages in rural Bangladesh. Nutritional deficiency is common problem faced by most of the villagers. Particularly, the condition of children and women in poor households is alarming. Poverty and food shortage is

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common to most of the poor families. Women and children suffer from some common diseases. There is no healthcare center in the village. Government hospital and clinics are located in *Saturai* about four kilometers away from the village. It has mentioned that the conditions of these healthcare centers are not good and the patients hardly visit those due to unable to go another healthcare center. A charitable dispensary is located in *Baliati* about two kilometers away from the village. A *Sobuj Sata* (green umbrella) healthcare centre is also located in *Baliati*.[1] Doctors from *Baliati* charitable dispensary sometimes visit the village. Family planning workers Hasina and Roushan also visit the village. There are two popular midwives (*dai*) in the village named Mala and Mirson who are basically untrained, and they perform most of the deliveries in the village. Some relatives and neighbors also perform most of the deliveries.

Photograph-4.4: Mala, a *Dai* of *Hazipur*

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Photograph-4.5: A Government Clinic in *Baliati* Where the Women Go for Reproductive Healthcare

Photograph-4.6: *Shaturia* Thana Health Complex Where the People of *Hazipur* Go for Healthcare

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4.10: Nutritional Conditions and Health

In 2005, *Child and Mother Nutrition Survey* (CMNS) of Bangladesh was carried out. At the same time were underway in public health nutrition in Bangladesh. The country was a signatory to achieving the MDGs of which three, MDG 1 for poverty reduction, MDG 4 for child mortality and MDG 5 for maternal health are directly related to nutrition. A "double burden of malnutrition" meaning the coexistence of under nutrition and overweight in the same population is emerging in the country due to economic development coupled with economic disparities.[2] It is reported that almost one-third women in Bangladesh are the victim of chronic malnutrition.[3] But this figure is many times higher in the rural areas of the country. Women and children are the major victims of malnutrition leading to high mortality and morbidity rates. The most important cause of under 5 mortality is malnutrition. Malnutrition has been attributed for about 55 percent of the total under five child mortality which very frequently is overlooked or not recognized precisely by most the medical professionals.[4] Amongst various causes of maternal mortality, malnutrition is responsible for the highest number of percent of case-fatality in a country where the prevalence of malnutrition has been identified as a public health nutrition problem like ours. In Bangladesh, malnutrition has been identified and recognized by all sectors of policy makers as the prime factor contributing to the overall high mortality rate of the people.

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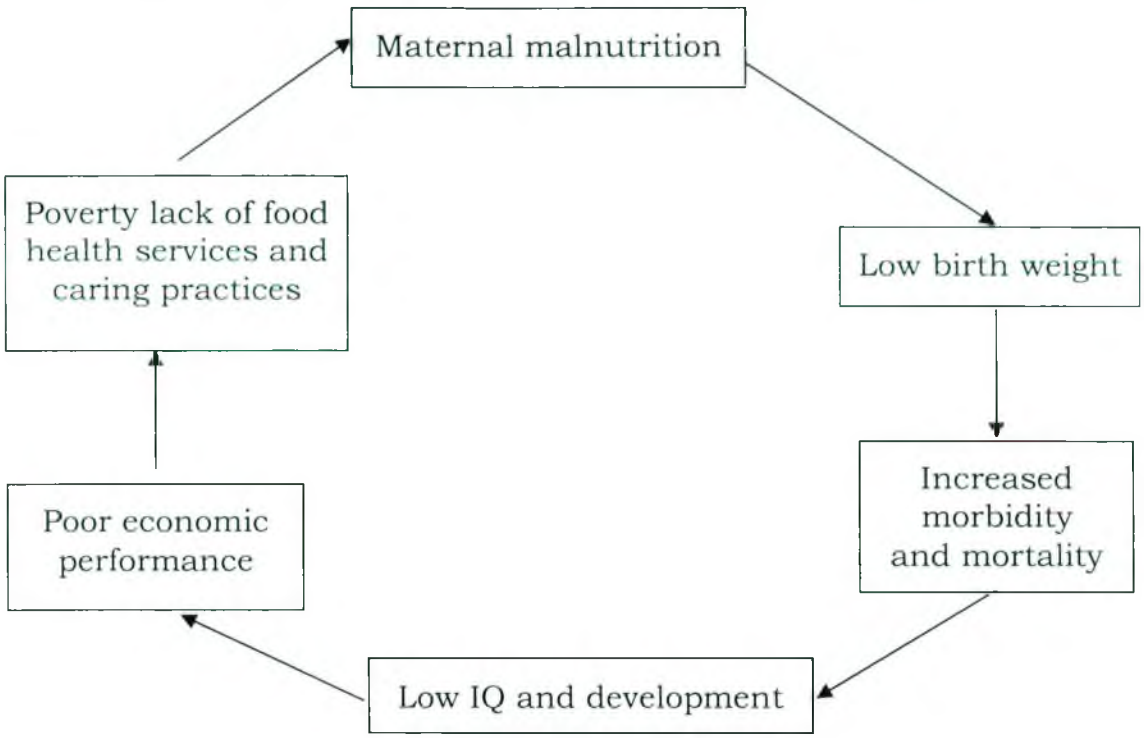
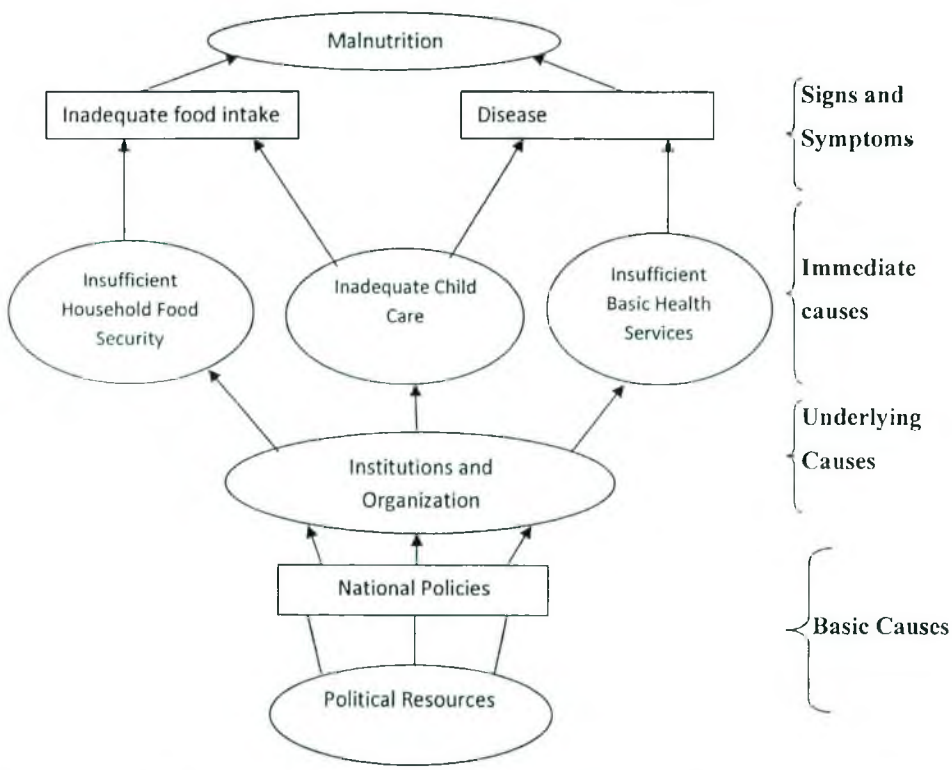
Chart-4.1: Relationships between Nutrition and Health



Source: AMM Anisul Awwal: Nutrition: The Foundation of Health and Development: Massline Printers, Dhaka, July, 2004; p. 10.

Chart-4.2: Factors Contributing to Malnutrition



Source: Adapted from the Joint WHO/UNICEF Nutrition Support Program in Iringa, Tanzania, 1988, p.3.

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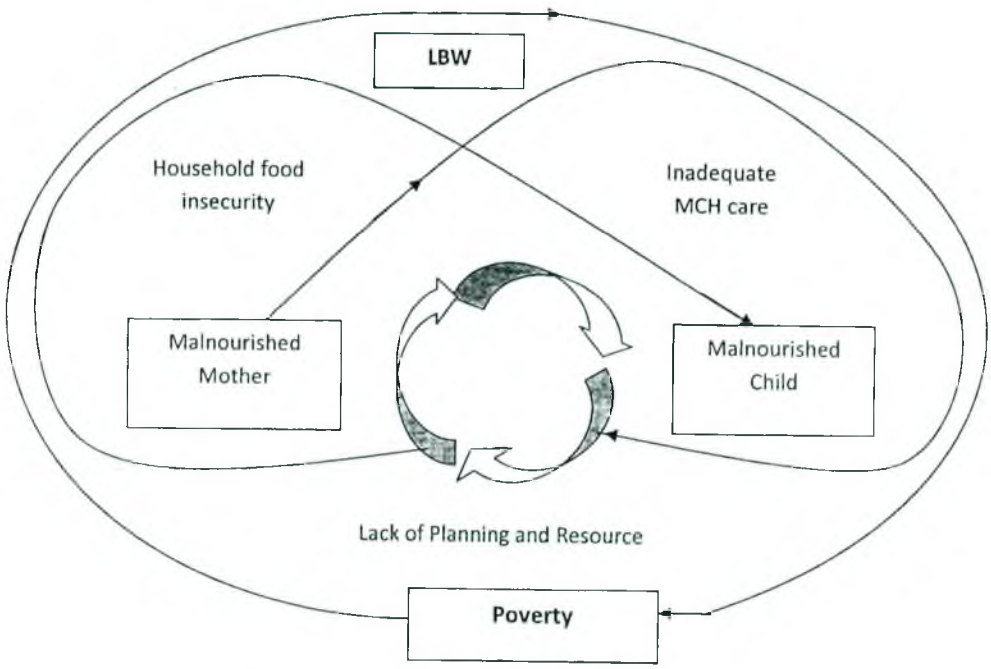
Studies on maternal nutrition show a predictive interrelationship between low pre-pregnancy weight low weight gain by 5.7 and 9 months of pregnancy and LBW. Low pregnancy weight is suggestive in women of chronic malnutrition commencing in early childhood. Study found that LBW infants are likely to become malnourished children. These effects are especially devastating in the case of girls. In many deprived populations like the rural area nutrition and healthcare of girls during their infancy and childhood is neglected. Chronically malnourished girls are therefore even more likely to remain malnourished during adolescence and adulthood when pregnant, to delivery low birth weight babies.

Chart-4.3: Malnutrition Cycle



Source: Dr. AMM Ansiul Awwal, Nutrition: *The Foundation of Health and Development*, Massline Printers, Dhaka, 2004, p. 18.

As a typical village of Bangladesh, *Hazipur* represents the nutritional conditions of overall Bangladesh particularly of the rural areas of the country. It has been found in the research field that the women are the main victim of malnutrition. Because of patriarchic family and social system, they are confined to the cycle of malnutrition from which they cannot come out. Another group of malnutrition victim is the children of poor households.

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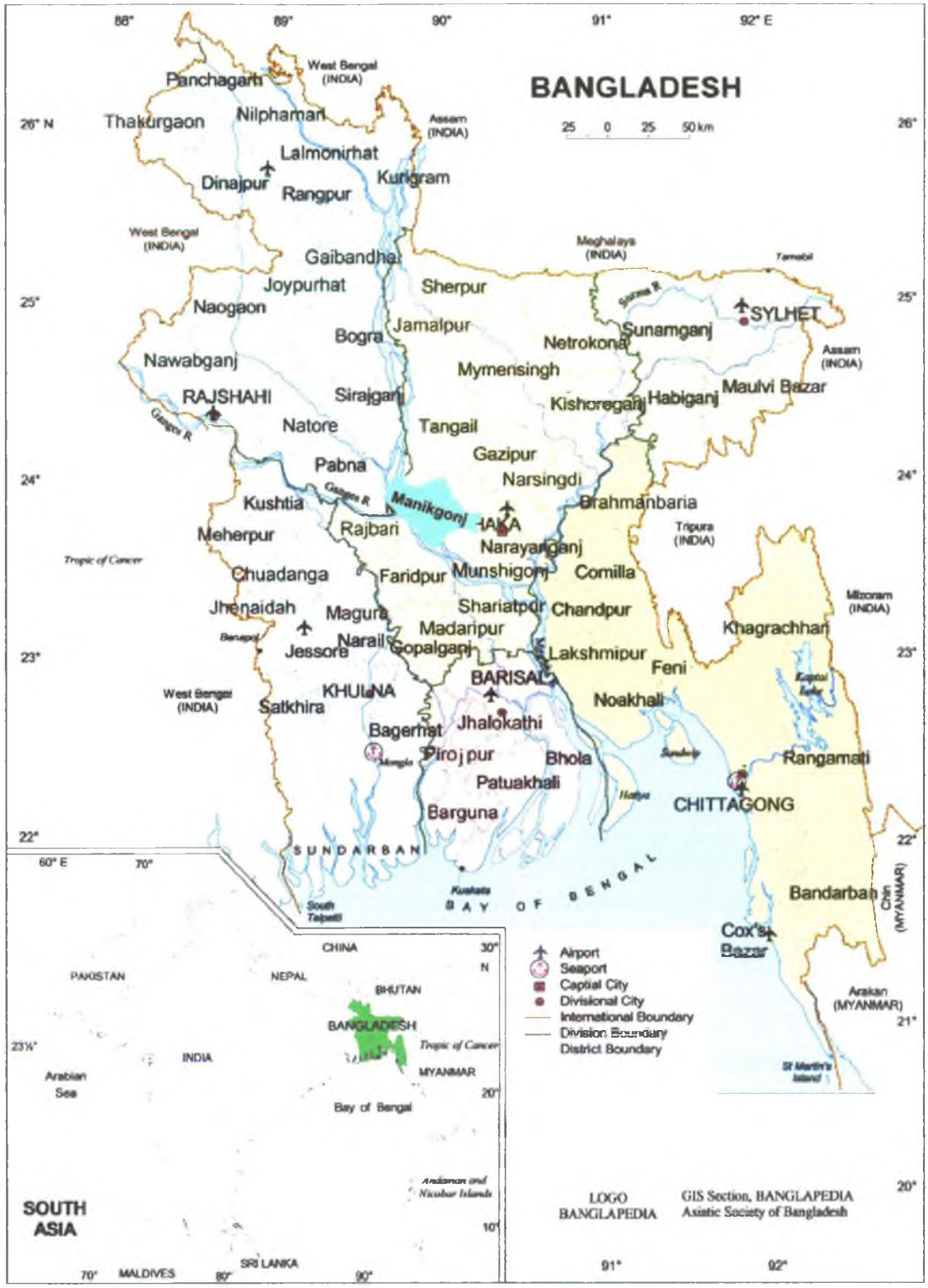
Map-4.1: *Manikganj* District in Bangladesh



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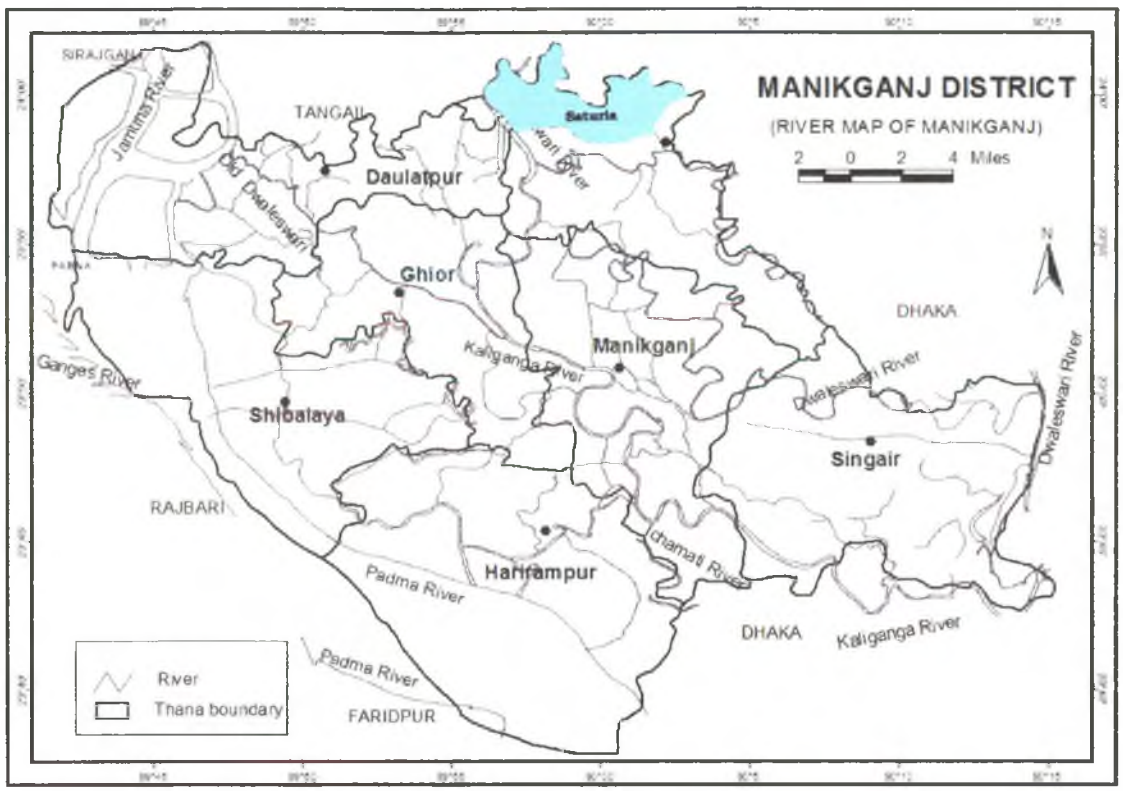
Map-4.2: *Saturia* Upazila in *Manikganj* District



Source: *Saturia* Upazila Office

Map-4.3: *Hazipur* in *Baliati* Union

Source: *Saturia* Upazila Office

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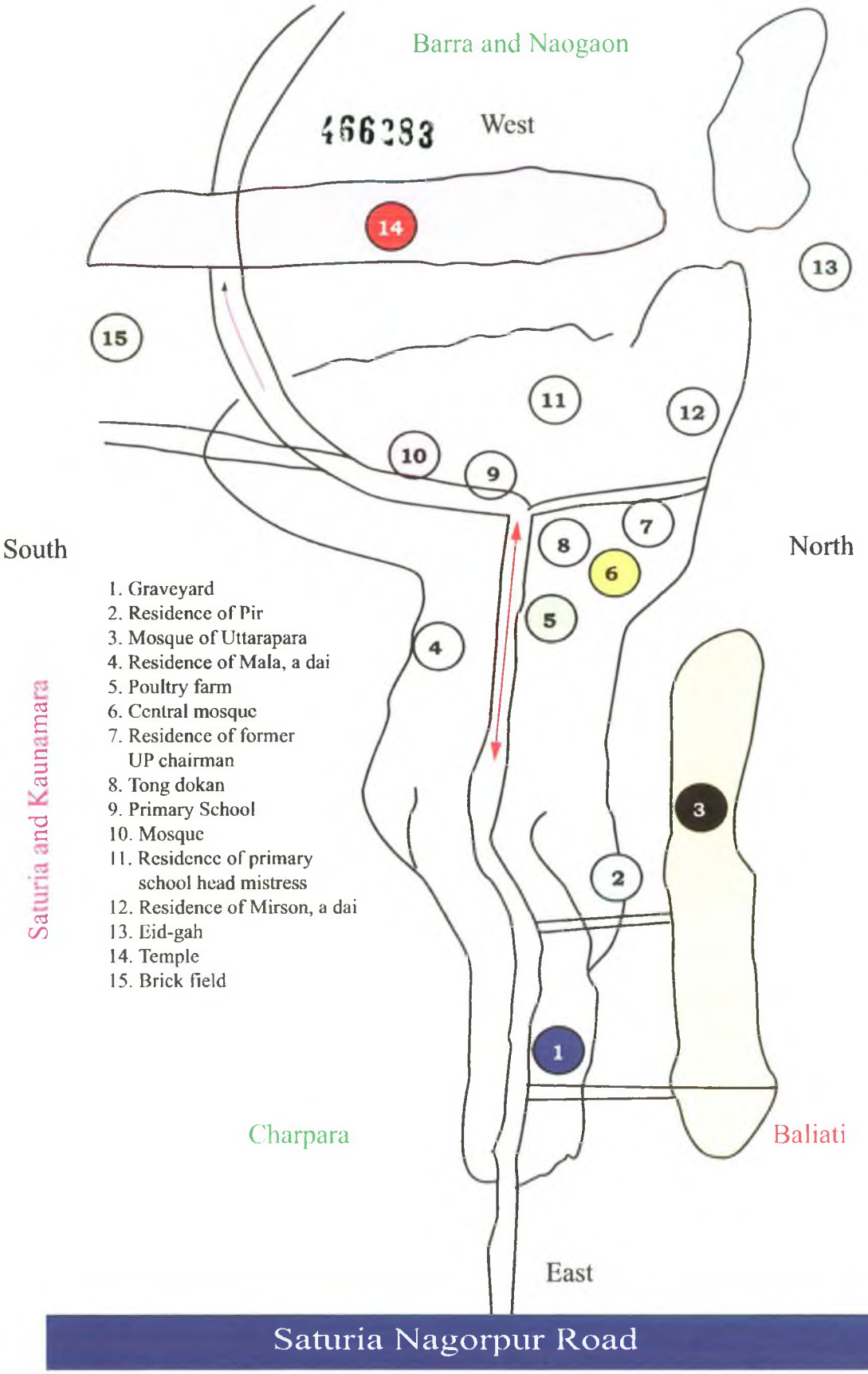
Map-4.4: Geographical Location and Important Points of *Hazipur* Village



ঢাকা বিশ্ববিদ্যালয় গ্রন্থাগার

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4.11: Conditions of Women

Health and healthcare of the rural women of Bangladesh cannot be understood in real sense without an overall understanding of their conditions in the family, society and state. Therefore, the following discussion attempts to present the general conditions of the rural women of Bangladesh. In the process, an insight of gender discrimination has been highlighted in order to present the real scenario.

Women and Their Families: In rural Bangladesh, traditionally the women have the basic tendency to put family and children first. Usually, they do not give priority to their health and try to overlook it for the sake of their husband and children. Attitude of sacrificing and mental structure stands behind it. But improving mother's health, preventing unnecessary maternal deaths would ultimately help in both ways for mothers as well as their child. From the very early in the morning women engage their household work with very much sincerity and devotion up to the completion of work. Then the women take rest or go to bed. But most of the times they cannot take necessary per capita kilocalorie and rest, which make their health sufferer. Not only she herself but all other family members also ignore her health and necessity. It is a tradition and unwritten rule of the country that women always have to give most and they take less, they have to cook, rear up children, take care all family members, wash cloths, clean the household, feed the pet animals, make the garden and many more things but during women's sickness or disease nobody cares and looks after. This is the most common scene in the rural areas of Bangladesh that after feeding all the household members if there is no food at all it is the women who have to starve. Married off to early, girls and women have very little to say in decisions related to family planning, pregnancy and reproductive healthcare

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though they are the ones who experience complicated, painful and often fatal pregnancies and deliveries.

Private Property and Women's Oppression: Marxist feminists think it is impossible for anyone, especially women, to obtain genuine equal opportunity in a class society where the wealth produced by the powerless may ends up in the hands of the powerful few. Friedrich Engels claims that women's oppression originates in the introduction of private property, an institution that obliterated whatever equality the human community had previously enjoyed. Private ownership of the means of production by relatively few persons, originally all male, inaugurated a class system whose contemporary manifestations are corporate capitalism and imperialism. Reflection on this state of affairs suggests that capitalism itself, not just the large social rules under which men are privileged over women is the cause of women's oppression.[5] This fact is very true in the case of the rural women of Bangladesh. They are not the owner of any property rather they are treated as the personal property of men. Inheritance law of the country under Muslim personal and family law discriminates and exploits the women. As a result, having no ownership of any key resources women are oppressed in all walks of life by male members of the family and society.

Patriarchal Ideology Oppresses Women: Radical feminists believe that neither their liberal nor their Marxist sisters have gone far enough. They argue that is it the patriarchal ideology that oppresses women, a system characterized by power, dominance, hierarchy, and competition, a system that cannot be reformed but only ripped out root and branch.[6] It is not just patriarchy's legal and political structures that must be overturned; its social and cultural institutions (especially the family, the church, and the academy) must also go. The rural women of Bangladesh live under the rule of patriarchy. In *Hazipur,* patriarchic rules and regulations are as strong and dominant that women's individual identity is very

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much questionable and burning issue. Whole gamut of patriarchy has been arranged to maintain male dominations and persuasion.

Biology is Destiny: When conservatives say that biology is destiny, they mean: (1) people are born with the hormones, anatomy, and chromosomes of either a male or a female; (2) females are destined to have a much more burdensome reproductive role than males; (3) males with others thing being equal, exhibit "masculine" psychological traits whereas females with other things being equal, exhibit "feminine" psychological traits; and (4) society should preserve this natural order, making sure that its men remain "manly" and its women "womanly."[7]

Women in rural Bangladesh are treated as a means of achieving male's goals—not an end. Even they do not have their own control over their bodies, these are under male control. Women's main role is sex provider and serving the family by providing with the labor of body.

Social Construction of Gender: Not all radical feminists focus on the biological origins of women's oppression however. Indeed, most focus instead on the ways in which gender (masculinity and femininity) and sexuality (hetero sexuality versus lesbianism) have been used to subordinate women to men. Unlike liberal feminists, however, who tend to deemphasize men's power over women and who quite often suggest "those men are similarly fellow victims of sex-role conditioning" radical feminists insist that male power, in societies such as ours, is at the root of the social construction of gender.[8]

All the radical feminists have had to say about sexual oppression by male sexual domination and female sexual submission through pornography, prostitution, sexual harassment, rape and woman battering, through foot-binding, *suftee, purdah*, clitoridectonmy, with-burning and gynecology, men have controlled

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women's sexuality for men pleasure.[9] This fact is very true in the case of the rural women of *Hazipur* as well as in rural Bangladesh.

Concept of Virginity and Women's Subordination: From the very childhood, a rural girl has to learn about virginity from her parents, relatives and society. They teach her that virginity for a girl is very much valuable matter and a virgin girl or woman has a great value in the society. They also teach the girl that it is the holly duty of all girls to preserve their virginity for the desirable husband and it is the duty of the husband to remove her (the girl) virginity himself. According to the society, it is really shameful to lose virginity before marriage and the girl who is not virgin anymore has no power and value in market because men like virgin girl. Even surprisingly, in this technologically advanced, modern society most of the men want virgin girls as their wives. But very interestingly most of those men are not virgin before their marriage. So, it's the duty of "the girls" to preserve their virginity for their husband, but those men have lost their virginity before marriage. Therefore, sense and efforts of maintain virginity creates women's subordination and consolidates the system of patriarchy.

Powerless Women and Girls: From psycho-analytical point of view, the powerlessness and helplessness of the rural women of Bangladesh rightly be analyzed. Psycho-analytic feminists find the root of women's oppression embedded deep in her psyche. Originally, in the pre-Oedipal stage, all infants are symbiotically attached to their mothers, whom they perceive as omnipotent. As a result of submitting his id (or desires) to the superego (collective social conscience), the boy is fully integrated into culture.[10] Together with his father he will rule over nature and woman, both of whom contain a similarly irrational power. In contrast to the boy, the girl who has no penis separates slowly from her first love object, mother. As a result, the girl's integration into culture is

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incomplete. She exists at the periphery or margin of culture as the one who does not rule but is ruled, largely because she fears her own power.

Women are Second Sex: The rural women of Bangladesh really belong to second sex and male first sex. Simone de Beauvoir's *The Second Sex*, probably the key theoretical text of twentieth century feminism, offered existentialities explanation of women's situation.[11] De Beauvior argues that women are oppressed by virtue of "otherness." Woman is the "Other" because she is "not-man". Man is the self, the free, determining being who defines the meaning of his existence, and woman is the other, the object whose meaning is determined for her. If woman is to become a self, a subject, she must like man transcend the definitions, labels and essences limiting her existence. She must make herself be whatever she wants to be.

Religion, Purity and Pollution: Emile Durkheim, the French Sociologist and Anthropologist, is best known for founding sociology as a scientific discipline and for defining the boundaries of its subject matter. *The Elementary Forms of the Religious Life*, Durkheim's fourth major sociological work, was written between 1902 and 1911. By the time it was published in 1912. He came with the concepts purity and pollution first in this classic book. To find out the origin of all religions, Durkheim shows that there are general tendencies in all religious belief to divide all things into two segments.[12] From this theoretical perspectives, we observe that a man is always pure and he is not polluted any time. On the other hand, a woman is polluted each and every month during her menstrual period, during her pregnancy, after the sexual intercourse with her husband, after child delivery. In many societies, they are thought as evil and polluted during these times. Many societies do not also permit women to cook food, touch any religious objects, valuable clothing, even they cannot participate in many festivals during these times. Society creates all those boundaries for women for

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the wellbeing of men. In that case, religion plays a vital role to remove women from the main wave of society.

Extramarital Relationship and Discriminatory Behavior: In Ancient society, a natural sexual relationship exists among men and women and that relationship was not particular. But with the concept of private property and inheritance, society had to decide a formal relationship between a man and a woman. From that time on, women become bounded to give up all types of sexual relationship without husband. According to Islam, if a man wants, he can marry four women on conditions to economic, mental and physical fitness and also for his inheritance. However, it is not accepted by at a time, when it necessary and done. But Islam does not unconditionally accept more than one marriage or more than one man for women as husband at a time. We can see the polygamous nature also in Hindu religion. In Hindu religion, there are many gods who are polygamous in nature and society and religion permit their tendency. In that case, we can mention the name of Lord Krishna who was one of the most powerful gods among the Hindu people.[13] He was badly involved with many women physically and among the most importantly we can mention the name of Radha. Because of this involvement, society did not blame Krishna rather made some pleasing songs named "*Kitton*" to the lord Krishna. On the other hand, it was Radha who lost her husband, relatives, social life, and honor because of this extramarital relationship.[14]The society is flexible to men and very much rigid to women in the case of extramarital affair. According to the society, it is the duty of women to hide her body from outside and preserve her virginity for only one person, her husband. She has to show her beauty to her husband and nobody else. Before marriage, a woman has to preserve her virginity for the husband and nobody can touch her because her everything is only for her husband. Her husband is the only owner of her everything. But this society easily grants the

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polygamous nature of men. There is nothing to be worried if a man has sexual relationship outside his marriage. During the time of arranging a marriage, a man and his family try to know about some information about the virginity of the girl and very interestingly, women and/or her family simply do not imagine collecting information about the virginity of the bridegroom. Because they accept this type of behavior in the name of religion, society, norms, values, and so on.

4.12: Conclusion

In the present study, *Hazipur* has elaborately been presented systematically from the perspective of its geo-physical and geo-political characteristics. For this purpose it has reflected on location, population, economy, educational institutions, transport and communication, social life and social relations, religion and religious life, nutritional conditions, conditions of the women etc. In the process, emphasis has been put on healthcare conditions and women's conditions of the village. It seems from almost all considerations that *Hazipur* is a typical village which represents most of the villages of Bangladesh. Therefore, the conclusions and predictions which have been made in this study likely to be applicable to the context of almost all villages of Bangladesh.

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Notes and References

1. *Sabuj Sata* is a healthcare program mainly for the rural women and children.
2. *Child and Mother Nutrition Survey of Bangladesh*, CMNSB- BBS, Dhaka, 2005, p.19.
3. The Daily Star, July 15, 2012.
4. AMM Anisul Awwal, *Nutrition: The Foundation of Health and Development*, Massline Printers, Dhaka, 2004, p. 9.
5. Rosemarie Tong, *Feminist Thought: A Comprehensive Introduction*; Westview Press, Inc., 1995, p. 2-9.
6. *Ibid*, pp. 2-9.
7. *Ibid*, p. 2-9.
8. *Ibid*, p. 2-9.
9. *Ibid*, p. 2-9.
10. *Ibid*, p. 2-8.
11. Simon De Beauvior, *The Second Sex*, Penguin Books, England, 1984.
12. Tong, *op.cit.* pp. 373-397.
13. Lord Krishna is the most powerful god to the Hindu people all over the world. According to Hindu mythology, Lord Krishna killed Konsho (who was the maternal uncle of Krishna and was a very cruel king of Mathura) in a war and established a peaceful kingdom in Mathura. Krishna has a lots of name like-Kala, Sham, Kalia etc.
14. Radha was one of the aunts of Krishna (maternal uncle's wife). Krishna forced Radha to make an extramarital affair with him (Krishna). Though they did not get married anymore, they had physical relationships and to the Hindu people, Radha and Krishna-the couple is the symbol of true love and they (Hindu people) think them as the most powerful god and goddess.

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Chapter 5

Women Empowerment in Family Domain on Reproductive Healthcare

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Chapter 5

Women Empowerment in Family Domain on Reproductive Healthcare

5.1: Introduction

In Bangladesh, traditional family system is very pre-dominated. Life cannot be lived in this society without family. A man or woman is born in family, lives in family, dies in family and his or her social identity is determined by the family he or she lives in. Property inheritance is also regulated on family line. Therefore, every person's life in Bangladesh is based on family which is the basic institution of the social structure as well as a domain of women empowerment. These facts are very true in the case of the rural people of Bangladesh. Particularly, women's lives in the rural society are regulated and controlled by their respective families. They always stay in the homestead, the domain regulated by the rules, customs and traditions of the family. Patriarchal family system makes division of works: men work in public spheres and women in private spheres.[1] In most of the cases, women are the most oppressed and neglected members of the family. They do not have the right to make family decisions rather family decisions are binding on them. Therefore, the present study has hypothesized that women empowerment in family domains may have significant impact on women's access to standard reproductive healthcare specifically. This chapter deals with how and to what extent women's empowerment in family domains correlates with the access to standard reproductive healthcare. In order to do that, various areas of family decisions have been located and examined their impact on reproductive healthcare.

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5.2: Participation in Everyday Family Decision on Healthcare in the Household

Generally, in the lives of the people of third world countries like Bangladesh, family is the core concept. However, people usually cannot think their existence as a social human being without family. This fact is more rigid the rural women of Bangladesh irrespective of age, class, social status, marital status, and so no. In this context, in economically poor, infra-structurally weak, superstitious social system the position of women is very sensitive. As a result, most of the women feel insecurity, frustration, depression outside of their family. For all of them, family is the ultimate shelter. From birth to young age a woman's paternal family (included father, mother, and brother, sister) is her shelter. After her marriage she wants to think her husband's family (included husband, brother in law) as her own and after the death of her husband she totally depends on her son's family (included son, daughter-in-law, grand children). In such narrated positions, women always search for their own home, but nowhere is their own home. However, the present study has assessed the impact of sharing in everyday family decisions on reproductive healthcare.

Table-5.1: Access to everyday family decisions with husbands

Status in everyday family decisions	Total	Percentage (%)
Equal sharing	38	11.66
Partial sharing	154	47.24
No sharing	134	41.10
Total	326	100

Source: Field data 2012

Table-5.1 presents women empowerment in regard to access to everyday family decisions. It has shows that 11.66 percent women have equal sharing in access to

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everyday family decisions with husband, 47.24 percent women have partial sharing and 41.10 percent women have no sharing in access to everyday family decisions with husbands. Following table (Table-5.2) deals with the impact of women empowerment that means the level of sharing in everyday family decisions on reproductive healthcare that means number of pregnancies.

Table-5.2: Number of Pregnancies of the Respondents by Participation in Everyday Family Decisions

Status in everyday family decisions	Number of Pregnancies			
	1-2	3-4	5+	Total
Equal sharing	24 (63.16%)*	12 (32.58%)	2 (5.26%)	38 (11.66%)
Partial sharing	82 (53.25%)	52 (32.77%)	20 (13.99%)	154 (47.24%)
No sharing	67 (50.00%)	43 (32.09%)	24 (17.91%)	134 (41.10%)
Total	173 (53.07%)	107 (32.82%)	46 (14.11%)	326 (100%)

Source: Field Data 2012
*Percentage of column within bracket

Table- 5.2 demonstrates an alarming scenario in rural Bangladesh from the view point of women's sharing in everyday family decisions. Data shows that only 38 (11.66%) respondents acknowledge that they have equal sharing with male members in everyday family decisions. Out of the total 326, 154 (47.24%) respondents acknowledge that they have partial sharing in this respect. On the other hand, 134 (41.10%) respondents realize that they have no sharing in everyday family decisions. Such conditions obviously indicate patriarchic domination in the rural society which has serious negative implications on women's healthcare behavior.

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The above mentioned table (Table-5.2) demonstrates that the women who have equal sharing in everyday family decisions 63.16% of them have 1-2 pregnancies. But this number is 53.25% and 50.00% respectively in the case of the women who have partial sharing and no sharing in everyday family decisions at all. Similarly, almost same number of pregnancies has been found among the respondents who have partial sharing or no sharing in family decisions. Therefore, the study concludes that the women who have more sharing in everyday family decisions they have almost similar number of pregnancies. The result of the chi-square also demonstrates that the relationship between the two variables is not visible here. At 5% sig. (level of significance) and 4 df. (degree of freedom) the table value is 9.49 and calculated value is 3.26 which is smaller than the table value. Therefore, the null hypothesis to be accepted, that means, there is no relationship between the two variables. It may be assumed that the women who can participate in everyday family decisions can also participate in their healthcare or health related decisions. But in reality, women have little access to such a strategic decision like healthcare. It is importantly noted that the number of pregnancies is high among the older women of *Hazipur*; the lowest rate of pregnancy is found among the younger women of the village.

Table-5.2 also shows that out of the total 326 respondents, 173 respondents have 1-2 numbers of pregnancies that means 53.07 percent women out of the total have 1-2 numbers of pregnancies. Among 326 respondents, 107 women that means 32.82 percent women have 3-4 number of pregnancies and 46 women that means 14.11 percent women of the total have five plus (5+) pregnancies. From the number of pregnancies, women's health condition may be termed almost well in condition.

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Table-5.3: Number of Children of the Respondents by Sharing in Everyday Family Decisions

Status in everyday family decisions	Number of Children			
	1-2	3-4	5+	Total
Equal sharing	28 (73.68%)	8 (21.05%)	2 (5.26%)	38 (11.66%)
Partial sharing	102 (66.23%)	42 (27.27%)	10 (6.49%)	154 (47.24%)
No sharing	82 (61.19%)	38 (28.36%)	14 (10.45%)	134 (41.10%)
Total	212 (65.03%)	88 (26.99%)	26 (7.98%)	326 (100%)

Source: Field Data 2012

*Percentage of column within bracket

Table-5.3 shows that 212 women that means 65.03 percent women had 1-2 children, 88 women that means 26.99% had 3-4 children and 26 women (7.95%) had 5 and above children. The above mentioned table shows that 73.68 percent women have equal sharing in everyday family decisions who have 1-2 children. On the other hand, the women who have partial sharing 66.23% of them have 1-2 children and this figure is 61.19% among the women who have no sharing at all in everyday family decisions. From the above figures the study concludes that the women who have equal sharing in everyday family decisions have almost equal number of children and similar level of participation in health related matters. The result of the chi-square demonstrates that the relationship between the two variables is not visible here. At 5% sig. (level of significance) and 4 df. (degree of freedom) the table value is 9.49 and calculated value is 3.13 which is smaller than the table value. Therefore, the null hypothesis to be accepted, that means, there is no relationship between the two variables. It means that

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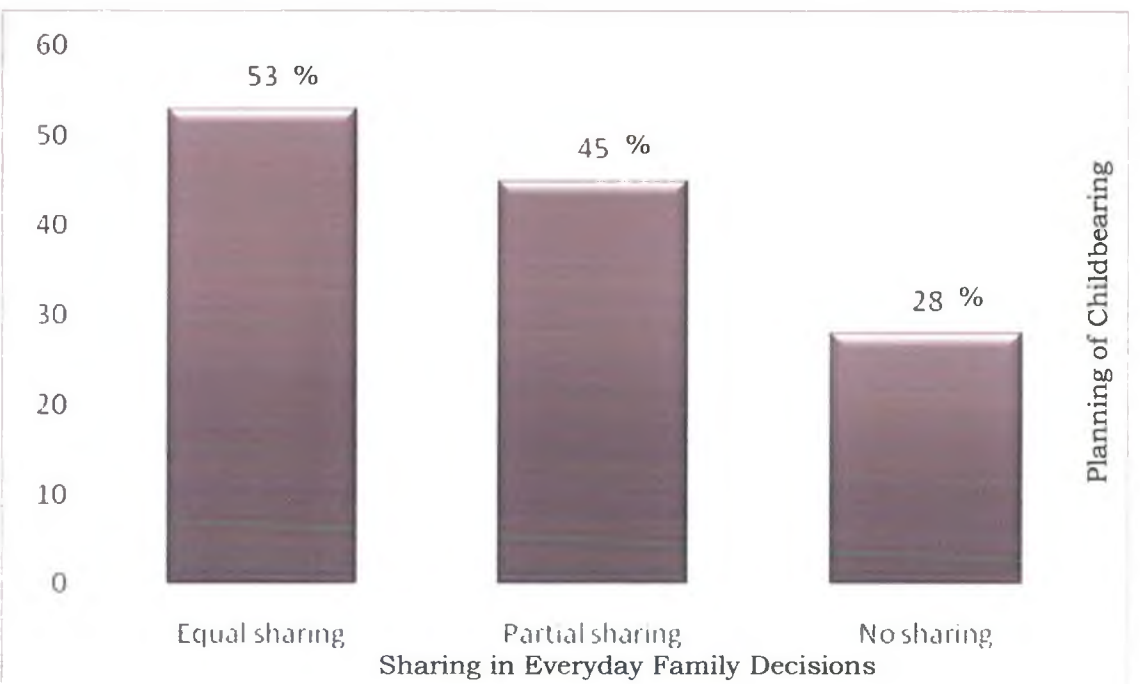
anthropological understanding of the nuclear family is that it dominates over the decision making and sharing of various aspects within the family. As a result, sharing and family decision have been gradually increased in rural and urban Bangladesh.

Field data shows that of the total respondents, only 39.88% childbearing is planned and the rest of 60.13% is unplanned. It indicates that whole life of the rural women is not so planned and women in most cases naturally become pregnant and give birth of child.

Graph-5.1: Planning of Childbearing by Sharing in Everyday Family Decisions



Source: Field Data 2012

Graph-5.1 demonstrates that out of the total (39.88) planned childbearing, 53.00 percent women have equal sharing in everyday family decisions, the figure in the case of partial sharing is 45.00 percent and no sharing is 28.00 percent. The Graph demonstrates that (100%-53%) 47.00 percent women have equal sharing whose child bearing was not planned; these figures are in the case of partial

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sharing is 55.00 percent and no sharing 72.00 percent. Therefore, the women who have more participation in every day family decisions, the child bearing more in number among them is generally planned. It is because of the fact that the decision about childbearing is alike other decisions of the family.

Table-5.4: Consultations with Doctor/Nurse of the Respondents by Sharing in Everyday Family Decisions

Status in everyday family decisions	Consultation with Doctor/Nurse		
	Yes	No	Total
Equal sharing	26 (68.43%)*	12 (31.58%)	38 (11.66%)
Partial sharing	72 (46.76%)	82 (53.25%)	154 (47.24%)
No sharing	44 (32.84%)	90 (67.17%)	134 (41.10%)
Total	142 (43.56%)	184 (56.45%)	326 (100%)

Source: Field Data 2012
*Percentage of column within bracket

Table-5.4 shows that only 142 (43.56%) respondents could consult with doctor/nurse during their pregnancies and rest of them 184 (56.45%) could not do that. The figures indicate an alarming picture of women's reproductive healthcare in rural Bangladesh. The Table demonstrates that 68.43 percent women who have equal sharing in everyday family decisions did consult with doctor/nurse, but these rates in partial sharing group is 46.76 percent and no sharing is 32.84 percent. On the other hand, 31.58 percent women have equal sharing in everyday family decisions who did not consult with doctor/nurse during their pregnancy, but the rate of partial sharing group is 53.25 percent and no sharing is 67.17 percent. So, it can be understood that the women who have

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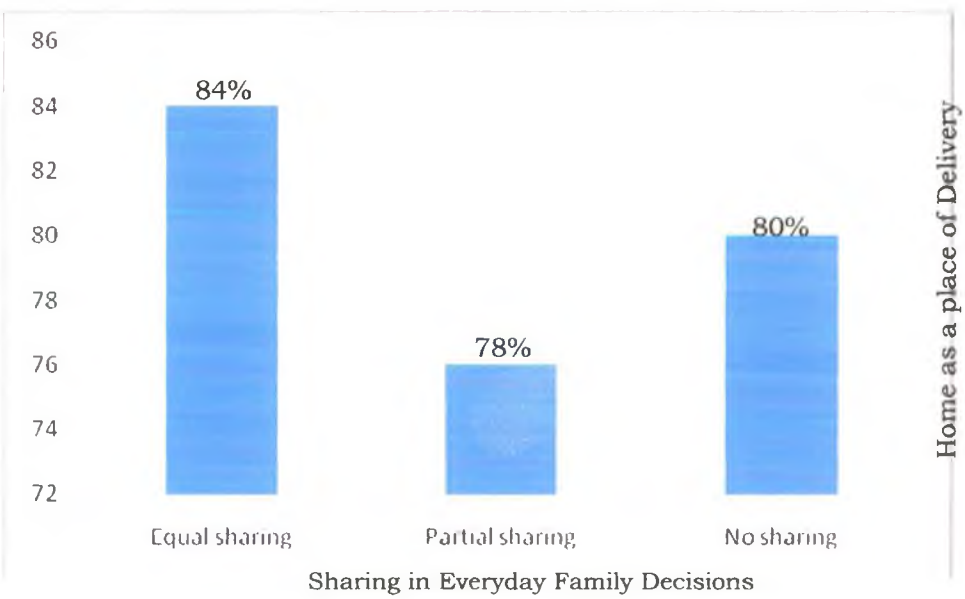
more sharing in everyday family decisions, they have more opportunity to consult with doctor/nurse during their pregnancy than the women who have less sharing in everyday family decisions. The result of the chi-square demonstrates that there is a relationship between the two variables. At 5% sig. (level of significance) and 2 df. (degree of freedom) the table value is 5.99 and calculated value is 16.43 which is bigger than the table value. Therefore, the null hypothesis to be rejected, that means, there is a relationship between the two variables. It may be noted that consulting doctor or nurse is also a family decision.

Field data shows that the deliveries of 258 (79%.15%) respondents out of the total 326 took place at home and only 66 (20.25%) at hospital or clinic. This clearly indicates very low standard of delivery condition in the rural areas of Bangladesh.

Graph-5.2: Home as the Place of Delivery of the Respondents by Sharing in Everyday Family Decisions.



Source: Field Data 2012

Graph-5.2 demonstrates that 84.00 percent women who have equal sharing in everyday family decisions whose deliveries have taken place at home, 78.00

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percent women of partial sharing group and 80.00 percent women of no sharing group whose deliveries have taken place at home. Most of the deliveries have taken place at home in *Hazipur* village, as well as the villagers prefer home other than hospital or clinic for delivering children. They also prefer midwife (*dai*) other than doctor/nurse/health worker. Of course, modern facilities for delivery are not available in the rural area like *Hazipur* and these are out of financial capacity for most of the patients.

Photograph-5.1: *Atur Ghor*, a Common Place of Delivery

Among 326 women of *Hazipur*, only 36 (11.04 percent) women asked that they have their own opinion during intercourse with their husbands, 154 women (47.24 percent) said that sometimes they have their opinion during intercourse and 136 (41.72 percent) have no opinion of their own.

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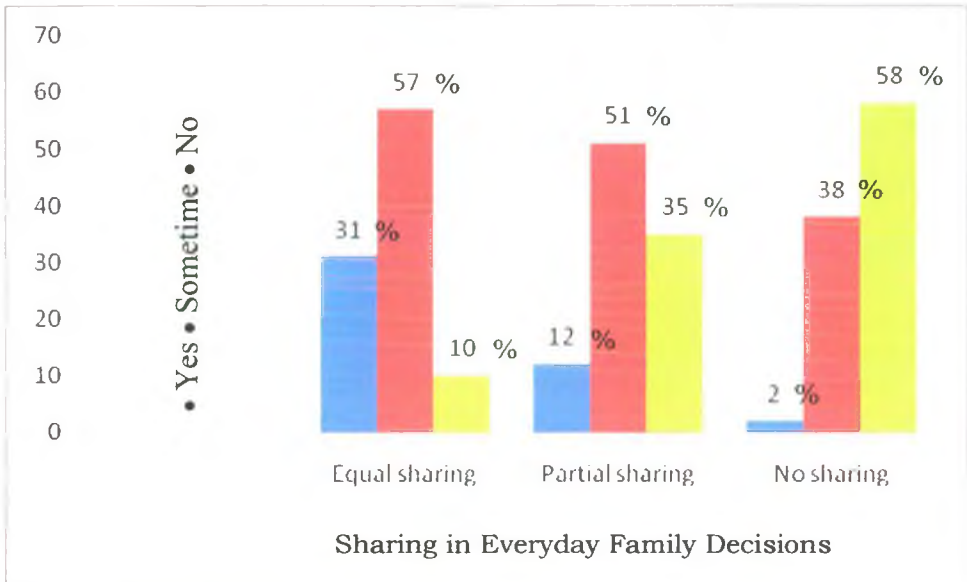
Graph-5.3: Opinions during Intercourse by Everyday Family Decisions



Source: Field Data 2012

Graph-5.3 shows that 31.00 percent women have equal sharing in everyday family decisions who have their own opinion during intercourse with their husbands, but this figure is 12.00 percent who have partial sharing and only 2.00 percent who have no sharing in everyday family decisions. On the other hand, 10.00 percent who have equal sharing in everyday family decisions, 35.00 percent partial sharing and 58.00 percent no sharing in everyday family decisions those have no opinion during sexual intercourse. Therefore, the higher is the level of equal sharing in everyday family decisions, the higher is the opinion obeyed during intercourse.

From the above discussion, it can be concluded that in the rural area of Bangladesh most of the women have no freedom anywhere including in the family decisions. Even during sexual intercourse, they cannot get enough co-operations from their husband or sexual partner. Many of them said that the wish of their husbands is the wish of them. Some also told me that sometimes their husbands make pressure on them during their bad physical condition, menstrual

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period, fever, pain. Many women expressed their horrible experiences. Sometimes husbands make force and then beat their wives for doing intercourse. As a result, the women become fearful about intercourse and are really become unhappy with their husbands but cannot express those to anyone. Therefore unequal and discriminatory participation in everyday family decisions exerts significant negative impact on women's healthcare.

5.3: Family Income and Expenditure on Healthcare

Table-5.5: Access to everyday family income decisions with husbands

Status in everyday family income decisions	Total	Percentage (%)
Equal sharing	22	6.75
Partial sharing	98	30.06
No sharing	206	63.20
Total	326	100

Source: Field data 2012

Table-5.5 presents women empowerment in regard to access to everyday family income decisions with husband. The data shows that 6.75 percent women have equal sharing, 30.06 percent women have partial sharing and 63.20 percent women have no sharing in access to everyday family income decisions with husbands. Following table (Table-5.5) deals with the impact of status in family income decisions on consultation with doctor/nurse.

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Table-5.6: Consultation with Doctor/Nurse of the Respondents by Sharing in Family Income Decisions

Status in family income decisions	Consultation with Doctor/Nurse		
	Yes	No	Total
Equal sharing	17 (77.28%)*	5 (22.73%)	22 (6.75%)
Partial sharing	58 (59.19%)	40 (40.82%)	98 (30.06%)
No sharing	77 (37.38%)	129 (62.63%)	206 (63.20%)
Total	142 (43.56%)	184 (56.45%)	326 (100%)

Source: Field Data 2012
*Percentage of column within bracket

Table-5.6 shows that only 22 (6.75%) respondents have equal sharing in family income decisions. On the other hand, this figure is 206 (63.20%) in the case of no sharing group. It reveals that the women of rural Bangladesh have very insignificant sharing in family income decisions with male members of the family. The above mentioned table (Table-5.6) demonstrates that 77.28 percent women who have equal sharing in everyday family income decisions who could consult with doctor/nurse, but the rate in the case of partial sharing is 59.19 percent and no sharing 37.38 percent. On the other hand, 22.73 percent women who have equal sharing in everyday family income decisions with their husband could not consult with doctor/nurse, and the rate in the case of partial sharing is 40.82 percent and no sharing 62.63 percent. Therefore, sharing in family income decisions positively correlates with consulting with doctor/nurse. The result of the chi-square demonstrates that there is a relationship between the two

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variables. At 5% sig. (level of significance) and 2 df. (degree of freedom) the table value is 5.99 and calculated value is 23.08 which is bigger than the table value. Therefore, the null hypothesis to be rejected, that means, there is a relationship between the two variables.

Table-5.7: Places of Delivery by Sharing in Family Income Decision with husbands

Status in family income decisions	Places of Delivery				
	Home	Hospital	Clinic	Other	Total
Equal sharing	18 (81.82%)*	3 (13.64%)	1 (4.55%)	0	22 (6.75%)
Partial sharing	68 (69.39%)	21 (21.43%)	9 (9.19%)	0	98 (30.06%)
No sharing	172 (83.48%)	24 (11.66%)	8 (3.89%)	2 (0.9%)	206 (63.20%)
Total	258 (79.15%)	48 (14.73%)	18 (5.52%)	2 (0.6%)	326 (100%)

Source: Field Data 2012
*Percentage of column within bracket

Table-5.7 demonstrates that the women who have equal sharing in family income decisions 81.82 percent of their deliveries took place at home. This figure is 69.39 percent who have partial sharing and 83.34 percent no sharing in family income decisions. From the above data and discussion, it is almost clear that participation in family income decisions has not much impact on the places of delivery of women. The result of the chi-square demonstrates that the relationship between the two variables is not visible here. At 5% sig. (level of significance) and 6 df. (degree of freedom) the table value is 12.592 and calculated value is 10.56 which is smaller than the table value. Therefore, the

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null hypothesis to be accepted, that means, there is no relationship between the two variables. The table also shows that 79.15 percent deliveries of *Hazipur* have taken place at home, 14.72 percent at hospital and 5.52 percent at clinic. Though the delivery at home is very much risky, village people prefer this place most of the times because of lacking of education, sufficient knowledge, poor economic condition, environmental circumstances, lack of good communication system, traditional belief, values, attitudes, and lack of modern medicare facilities. As a result, a huge number of maternal deaths is witnessed each year. Many infants also die each year in Bangladesh because of the delivery system at home due to untrained midwives.

The study has assessed the impact of family income decisions on other aspects of women's reproductive healthcare in rural Bangladesh. It has been found that positive relation between the two variables exists in most of the cases. Therefore, it seems that access to family income decisions facilitates the women in many ways to access to standard reproductive healthcare.

Table-5.8: Everyday family expenditure decisions with husbands

Status in family expenditure decision	Total	Percentage (%)
Equal sharing	18	5.53
Partial sharing	76	23.32
No sharing	232	71.17
Total	326	100

Source: Field data 2012

Table-5.8 and 5.9 present women empowerment in regard to everyday family expenditure decisions with husbands. The data shows that 5.53 percent women have equal sharing, 23.32 percent women have partial sharing and 71.17 percent women have no sharing in everyday family expenditure decisions with husbands.

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Table-5.9: Number of Children by Sharing in Family Expenditure Decisions with Husbands

Status in family expenditure decision	Number of Children			
	1-2	3-4	5+	Total
Equal sharing	14 (77.78%)*	4 (22.23%)	0	18 (5.53%)
Partial sharing	47 (61.85%)	18 (23.69%)	11 (14.48%)	76 (23.32%)
No sharing	151 (65.09%)	66 (28.45%)	15 (6.47%)	232 (71.17%)
Total	212 (65.04%)	88 (26.100%)	26 (7.98%)	326 (100)%

Source: Field Data 2012
*Percentage of column within bracket

Table-5.9 demonstrates an alarming scenario of women's empowerment in the contemporary power structure in the rural area. Because family expenditure decision is considered the most vital decision in a family but this key decision is monopolized by male members of the family. Table-5.8 shows that only 18 (5.52%) respondents have equal sharing with men in family expenditure decisions. It may be noted that pursuing healthcare services is in fact included with family expenditure decisions.

The table (Table-5.9) demonstrates that the women who have equal sharing in everyday family expenditure decisions 77.78 percent of them have 1-2 children, 61.85 percent of partial sharing and 65.09 percent no sharing who has the same number of children. There is no woman who has equal sharing in everyday family expenditure decision who has 5 and above children. That means the women who have equal sharing in everyday family expenditure decisions and who do dot have both of them have almost same number of children. From the

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analysis, it may be concluded that the number of children and status in family expenditure decision do not positively correlate. The result of the chi-square demonstrates that the relationship between the two variables is not visible here. At 5% sig. (level of significance) and 4 df. (degree of freedom) the table value is 9.48 and calculated value is 7.31 which is smaller than the table value. Therefore, the null hypothesis to be accepted, that means, there is no relationship between the two variables.

Photograph-5.2: A Child Cares another Junior Child in the Family

The study has assessed the impact of family income and expenditure decisions on other aspects of reproductive healthcare. It has been found that family expenditure decision is very much associated with healthcare services. In reality, the women who have more access to family income and expenditure decisions

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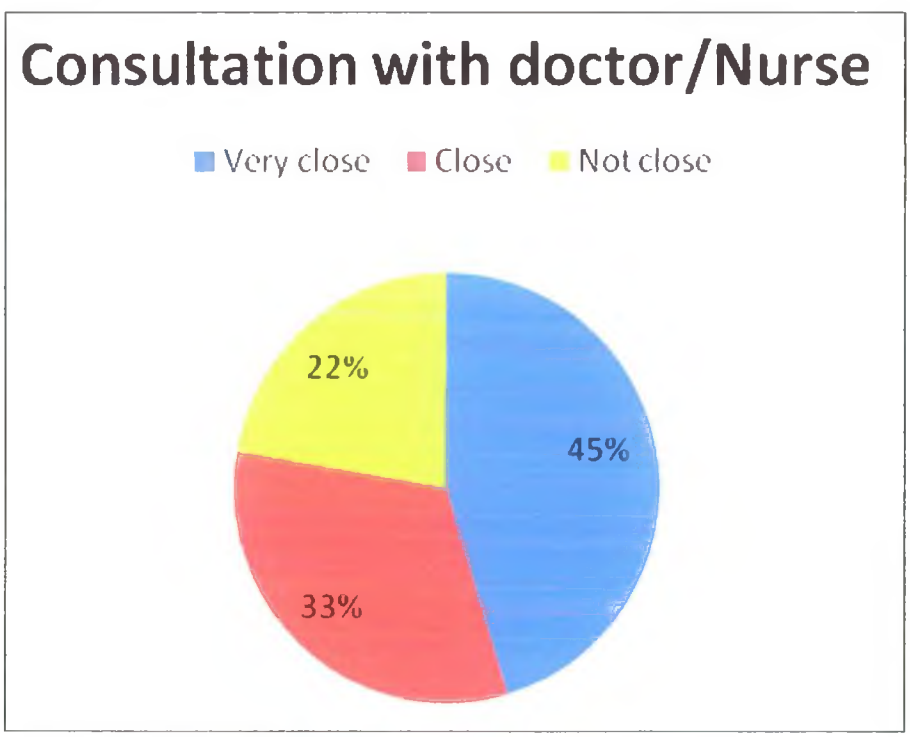
she may have more access to healthcare services. Because, the women who are educated or in service share family income, and consequently they play vital role in various spheres of their lives.

5.4: Closeness to Head of the Family on Healthcare

Apart from other factors which influence women empowerment in family domain, one's closeness to head of the family in this respect is important. As it may be assumed that the head of the family is the ultimate distributor of the family resources.[2] Therefore, closeness to head of the family may influence women's healthcare services. It has been found that only 5% respondents realize that they are very close to head of the family and most of the respondents are more or less and/or not close. The figure indicates a negative scenario about the relationship between head and other female members of the family. Ordinary female members are not normally close to an authoritarian head of the family.

Graph-5.4: Consultation with Doctor/Nurse by Closeness to Head of the Family



Source: Field Data 2012

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Graph-5.4 demonstrates that the women who are very close to head of the family 45.00 percent of them did consult with doctor/nurse but this figure is 33.00 percent who are close to head of the family and 22.00 percent who are not close to head of the family. Therefore, closeness to head of the family exerts positive impact on women's consultation with doctor/nurse during pregnancy. We have dealt with other elements of reproductive healthcare and found positive impact of closeness to head of the family in most cases.

The study has assessed the impact of closeness to head of the family on the places of delivery. It is observed that 87.00 percent women who are very close to head of the family whose deliveries have taken place at home, but this figure is 81.00 percent who are close and 80.00 percent who are not close to head of the family. Data shows that closeness to head of the family has no positive impact on the places of delivery. It is because of the fact that most of the deliveries take place at home irrespective of closeness to head of the family and/or other factors.

Photograph-5.3: Child Caring in the Family

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5.5: Participation in Family Healthcare Decisions on Healthcare

During my fieldwork in *Hazipur*, I have closely and intensively observed the lives of the women of that village. Obviously, there is a sharp distinction between the older aged women and the younger women. Most of the old aged women said that during their time they could not participate in any of the decisions of their families. It should be noted here that before few decades there was a common family structure in all of the villages of Bangladesh that was 'joint family structure'. Joint family includes older father, mother, their younger children, their wives, grandchildren etc. This type of large family is called joint family. Contemporary society of Bangladesh is going to shift from traditional agriculture to industry. It is now much dependent on industry, and diversified occupational activities, and so on. As a result, the joint family structure is gradually disappearing from the village area of Bangladesh. With the advancement of modern social norms, values, belief as well as socio-economic condition of the people want to live separately from their parents, relatives, and interested to establish nuclear family included only husband, wife and children. This is another significant reason for breaking down joint family.

In *Hazipur,* most of the old women (above 50) replied that at their young age they did not go to school, had no television, newspaper, mobile telephone and healthcare facilities. Then the society was also very much restricted by *purdah.* Even their husbands did not allow them to take any type of contraceptive; they were not familiar with family planning, small family, and contraceptives. In their families, they had old aged father-in-law, mother-in-law, elder brother-in-laws, their husbands and many more people. So, they even could not imagine participating in any decision related to the family or household or even their healthcare. Those older aged women said that sometimes they faced many major physical difficulties and felt pain and became sick. But they could not express

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those difficulties in front of the family members because of shyness and if sometimes they did express, their voices did not get any kind of help. So, according to them, during their time it was unimaginative to participate in family healthcare decisions. They also said that they have given birth their children and the gap between two children was only minimum one or maximum two years. During their delivery they felt pain and have given birth their children and after sometimes rest (one day or some hours) they have backed to their works. Because the people thought pregnancy and delivery are very much natural processes in any woman's life. The older women opined that things are changed today.

In *Hazipur*, most of the young aged women said that though they have no participation in all family affairs with men, in some matters sometimes they can participate. Most of the women said that during their pregnancy they try to consult with doctor/nurse/health worker, use contraceptives, try to get medical facilities during their bad health condition and most of the time their husbands help them in these matters. They know many things about healthcare matters than their mothers, mother-in-law; In recent years they have enough facilities to know and get healthcare. They also said that they try to participate in family's healthcare decisions because they know that this family is also her and she can do better for her family, husband and children. But they also said that if they wish to do anything in any matter like healthcare, they have to take permission of their husbands. Therefore, women's participation in family healthcare decisions is confined by the permission of their husbands and/or head of the family. Women's meaningful participation in this area has hardly been observed.

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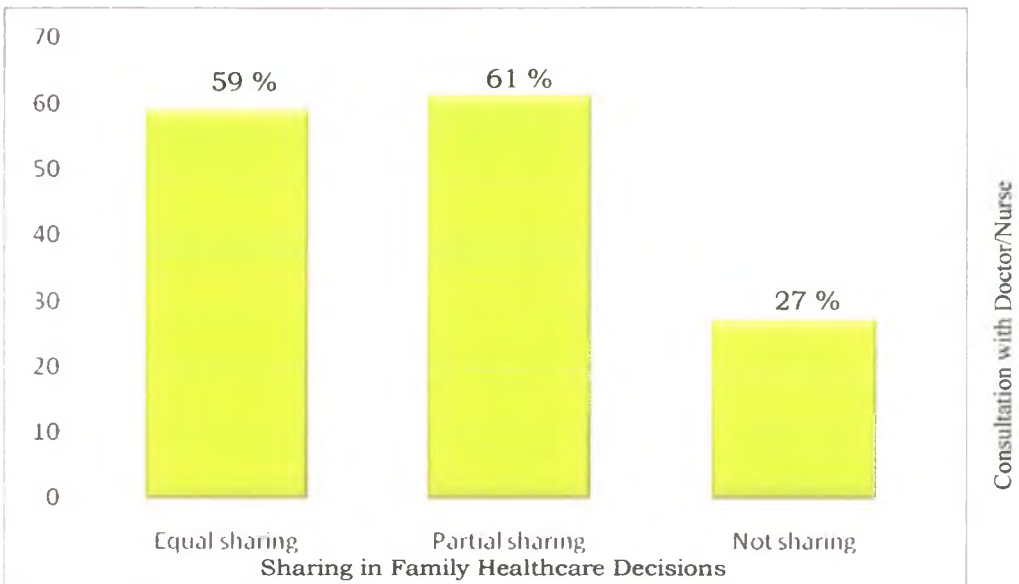
Graph-5.5: Consultation with Doctor/Nurse by Sharing in Family Healthcare Decisions



Source: Field Data 2012

Apart from other factors, the study has assessed the impact of one's status in family healthcare decisions on women's reproductive healthcare. The study has found that the two variables positively correlate. Graph-5.5 demonstrates that 59.00 percent women have equal sharing in healthcare decisions, 61.00 percent women have partial sharing and 27.00 percent women have no sharing to healthcare decisions who consulted with doctor/nurse/health worker during pregnancy periods. On the other hand, the women who have equal sharing in healthcare decisions 41 percent of them could not consult with doctor/nurse. But this figure is 39 percent in the case of partial sharing and 73 percent in no sharing. That means equal sharing or partial sharing in healthcare decisions in the family has significant impact on consultation with doctor/nurse/health worker during pregnancy.

An assessment has been made about the impact of sharing in family's healthcare decisions on other aspects of women's reproductive healthcare. It has been found that sharing in healthcare decisions has positive impact on almost all elements of

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women's healthcare. It is usual that one's sharing in family decisions will be used in his/her own favor.

5.6: Size of the Family on Healthcare

Medical facilities or healthcare is the basic fundamental human right for all human beings. Because of many reasons people cannot meet that fundamental right. Among the causes, poverty, size of the family, education, environment, communication system, attitude, belief system, gender discrimination etc are important. Family size, that means, how family members live in a particular family that has a very significant impact on healthcare facility apart from the resources endowed in a family.[3] If a family has a very few members, it can meet its healthcare demands easily but if a family has a large number of members, it is not always be possible for them to take necessary action during any crisis moment. It is true not only for healthcare facilities but also in every necessities of life. So, family size is important to understand healthcare or type and facilities of healthcare.

During the fieldwork in *Hazipur*, it has been found that there are many joint and extended families which cannot meet their healthcare demands because of their more number of family members. Many families of the village are not very much solvent economically and most of them have more than seven family members. As a result, they cannot take proper Medicare facilities during their bad health conditions. In these families, there is serious imbalance between family resources and size of members. On the other hand, there are few families in the village who have only four/five family members and as a result of small family size they can easily get proper medicare facilities like doctor from the nearby hospital, medicine and other type of special treatment. Therefore, it has been observed that family size and healthcare are very much related. Family size has significant impact on healthcare facilities. Particularly, the female members

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of a big size family are the most oppressed by the rigid rule of joint family. Of course, the resource endowed with a family is an important consideration in this respect.

Table-5.10: Size of the Families of Respondents

Size (Number of member)	Total	Percentage (%)
1	2	0.61
2	36	11.04
3	61	18.71
4	87	26.69
5	73	22.39
6	44	13.50
7+	23	7.0
	326	100

Source: Field data 2012

Table-5.10 shows the size of the families of the respondents. It has been found that most of the families consist of 3 to 5 members.

5.7: Openness to Family Members on Healthcare

Openness is also an important phenomenon which is related to healthcare from various dimensions. If there is openness among all of the family members in a family, a family member can express his/her sickness or bad health conditions to all of the family members and can get proper treatment as soon as possible.[4] But if anyone is not much open to his/her family members or the family is not much liberal to its family members, then it can create problems; because during any bad health condition or any health problem family members can feel shy or uneasy to express their grievances and may not get healthcare on the right time.

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And sometimes because of lacking of openness and care, many people die each year not getting medical support on right time.

Table-5.11: Sharing to other family members

Sharing	Total	Percentage (%)
Very Open	15	4.60
Open	259	79.45
Not Open	52	15.95
Total	326	100

Source: Field data 2012

Table-5.11 presents women empowerment in regard to sharing to other family members. It shows that 4.60 percent women are very open, 79.45 percent are open and 15.95 are not open to other family members of the research area.

Many people also become disabled both physically and mentally because of lacking of openness to family members. Assessing the impact of openness to other family members on healthcare and it has been found that lack of openness is a serious obstacle to getting proper healthcare. Particularly, women's introvertiveness and family's conservative nature deprive women of proper and adequate healthcare services. Society and family has made the rural women *lajuk* or *lojjabati* (shy) which obstructs them to be open.[5] Such a condition has mostly observed in the illiterate and conservative families.

5.8: Family Authority System on Healthcare

Household is the oldest social unit, which is responsible for managing family affairs. Table-5.7 shows men dominance in the family. It shows that 88.71% of the total households at the national level were headed by men in 2007 whereas

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only 11.3% were headed by women. At rural level, this figure was 88.6% and 11.5% respectively.[6]

Table-5.12: Respondent's nature of family authority

Family authority	Total	Percentage (%)
Liberal	64	19.63
Moderate	224	68.71
Conservative	38	11.66
Total	326	100

Source: Field data 2012

Table-5.12 presents respondent's nature of family authority. It shows that 19.63 percent women's families are liberal, 68.71 percent are moderate and 11.66 percent are conservative in nature.

Table-5.13: Percentage Distribution of Households by Sex of Head of Household and Residence, 2000-2007

Year	National		Rural		Urban	
	Women	Men	Women	Men	Women	Men
2000	12.8	87.2	12.8	85.7	7.6	92.4
2001	12.9	87.1	12.9	85.6	7.7	92.3
2002	10.4	89.6	10.9	89.1	9.1	90.9
2003	10.5	89.5	11.0	89.0	9.1	90.9
2004	10.3	89.7	10.2	89.8	10.4	89.6
2005	10.4	89.6	10.4	89.6	10.4	89.6
2006	10.4	89.6	10.4	89.6	10.4	89.6
2007	10.3	88.7	11.5	88.6	11.0	89.0

Source: *Report on Sample Vital Registration System, 2007,* BBS, Dhaka, pp. 3-4.

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It is observed from the table (Table-5.13) that the percentage of men dominated households in Bangladesh increased from 87.2% in 2000 to 88.7% in 2007. On the other hand, the percentage of women headed households declined from 12.8% in 2000 to 11.3% in 2007. It is also observed from the table that in 2000 men domination in the urban area was higher compared to that in rural area. After that a declining trend was observed in this respect. But in 2007 men's domination in households were almost same in urban area 89.0% and rural area 88.6%. On the contrary, women dominated households in the urban area increased from 7.6% in 2000 to 11.0 in 2007. In 2007, women headed households increased by one percentage at national and rural level over 2006. In urban area it also increased by 0.6% percent. In 2007, women headed household in the rural area was 11.5% compared to 11.0% in the urban area.[7]

From the above discussion, it is very clear that most of the households in the rural area are patriarchal or headed by male members. Male members establish their power everywhere of their family matters like food, education, marriage, healthcare etc. So, it is understood that most of the time their (male) decisions are final for everyone of the family/household. Family authority, family power, family decision is very much dependent on the male members. Most of the time males express their views as like as it is the rule of the family. The head of the family is thought as a superior one and other members of the family are the general mass people. He can do anything in the family. During the fieldwork in *Hazipur,* the present study has observed the same scenario in the village. Most of the families in the village are male headed and under patriarchic control and domination.

A woman of *Hazipur* describes a story which has been narrated below:

> 20 years ago Ramiza Begum, wife of Matin Mia, had four daughters. Matin did not like daughters and always wanted to be a

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proud father of some sons but he had not any son. After the delivery of his wife, hearing the news about giving birth of a daughter, Matin went away from home. He did not feed his daughters properly because of their female sex. When his wife Ramiza conceived fifth times, Matin hoped to be the father of a son, but after delivery, Matin saw another daughter (5^{th} number). Matin told her wife not to feed the 5^{th} daughter any more. After two days of delivery, the baby girl died. Matin told Ramiza not to cry for the girl; if Ramiza would cry, Matin will also kill Ramiza. In one hand, the pain and sorrow for the deed baby girl and on the other hand, fear about herself, after one day of the death of the girl, Ramiza also died during taking her prayer. Ramiza died because she could not tolerate such pain. If she could cry, she might not die.

Case Study 1

Rahela Begum, age 36, told me a horrible story of her life. She states:

I got married when I was only 13. I have 4 children and I work very hard from very early in the morning till mid night but cannot feed well all of my children. My husband is a poor peasant. Both my husband and I do not know how to read and write. There are many untold happenings in my life which cannot be expressed in front of my husband or anyone. During my last delivery 5 years ago, an accident happened. During my delivery, some places of my vagina torned up and that were really very much painful experience. Still today I am suffering from it because when I take any extra load by myself my urine goes down spontaneously and I cannot get rid of that. Because of poverty and my husband's ill-behavior I cannot do any medicare. In this situation, I think I won't exist in the world more.

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From the above incidence it is almost clear that the lives of the poor women of Bangladesh are full of pain and it is mainly because of their family authority system and their inadequate healthcare facilities. Most of the time the rural women cannot take necessary action during their very bad health conditions because of rigid family authority system. There are many cases where women and newborn babies die because of rigid family authority system as those women and babies cannot get help from their families. On the other hand, liberal authority system in the family is conducive to get proper healthcare and cooperation on the time of dangers. It is particularly important to note that even the authority system of some rich and educated families are conservative and authoritarian.

5.9: Family's Religious Practices on Healthcare

Most of the people of Bangladesh practice their respective religions in their daily lives. Though it is thought that the rural people are more religious than the urban ones, it is not always true. Most of the people are Muslims and they also do not know how to pray 5 times a day. They even do not know many things about Islam. Particularly most of the rural women are religious although they do not know how to read the Quran. In fact, they are religious in faith but not in practices. When I asked them about the performance of their religious activities they replied me that they only know that Allah exists and He knows everything. But most of them think that they live with religions.

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Table-5.14: Respondent's religious thought

Religious nature	Total	Percentage (%)
Secular	12	3.68
Moderate	178	54.60
Religions	146	44.79
Total	326	100

Source: Field data 2012

Table-5.14 presents respondent's religious thought. It shows that 3.68 percent women's families are secular, 54.60 percent women's families are moderate and 44.79 percent women's families are religions in nature.

In *Hazipur*, only rich women observe *purdah*. Their family authority system removes them from the outside world and confines them at home. On the other hand, poor women work hard whole day. They work both inside and outside of home and for this reason they cannot manage *purdah* in their daily lives. Their incapability to observe *purdah* is overlooked by the rigid social rules. Of course, some educated families hardly observe *purdah*.

The rural women obey the rules of patriarchy in their lives. They hold these and transmit these from generation to generation. Majeda Begum, age 55, narrates the story:

> I have 6 children. All of my family members are very religious. Even my daughter-in-laws are also. I have taught them that no one should argue with her husband as husband is her master. During my whole life I did not argue with my husband. Sometimes I felt trouble, pain during my intercourse and sometimes I was sick but I never denied

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> my husband to do the intercourse because Allah does not like it. Allah would not be pleased on me if I would not make my husband pleased. According to *Hadith*, do not deny your husband during intercourse otherwise you would not go to the heaven.

The study has found many women in the village who do not or cannot take modern medicare facilities because of rigid religious practices. Many women think that use of contraceptives is against the order of religion; so they do not use those. They also think that it is a sin to show her body or tell about any physical problem to doctor. Because of rigid *purdah* system many women cannot come out from home. We have found a few numbers of religious families who did not permit their female members to go to hospital even for medical help during physical complications. Going out of home is treated as the violation of *purdah* as well as religious prohibition. As a result, a huge number of the rural women of Bangladesh become very much deprived of modern medicare facilities or healthcare facilities of the world.

5.10: Right to Spatial Mobility on Healthcare

Women's right to spatial mobility and healthcare are very much interrelated. If a woman can enjoy the right to move anywhere, she can get the proper healthcare on proper time. On the other hand, if she cannot enjoy the right, sometimes it creates some difficulties. If a woman has no right to physical mobility, she cannot go to doctor, hospital or any medical centre for healthcare services. Therefore, the right to spatial mobility is a prerequisite for accessing to standard healthcare. That is why, it has been assumed that women's healthcare is dependent on the right to spatial mobility.

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Table-5.15: Access to mobility of respondents

Right to physical mobility	Total	Percentage (%)
Yes	54	16.56
Conditional	246	75.46
No	26	7.98
Total	326	100

Source: Field data 2012

Table-5.15 presents women empowerment in regard to access to mobility of respondents. It shows that 16.56 percent women have right to physical mobility, 75.46 percent women have conditional physical mobility and 7.98 percent women have no access to physical mobility.

In *Hazipur,* I have talked with many women and most of them told me that in fact they have no right to physical mobility. They also told me that if they wish to go anywhere, they have to take the permission of their husband; if husband is not at home then they have to go to their mother-in-law for permission. If she (mother-in-law) says 'yes' then the woman can go out from home. But it is the male member of the family who has the right to permit the female members to go anywhere. If one is permitted she is generally accompanied by male members.

Interestingly, almost all the women of *Hazipur* told me the same story. They told me that if they wish to go outside of the village or their parents' home, they have to go certainly with their husbands or any male members of the family. Otherwise, they usually cannot go. This is true in every case of their lives. So, they cannot go alone for taking healthcare facilities from any doctor, nurse, health worker, hospital, clinic etc. Their rigid physical mobility sometimes

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creates some problems to get proper medical or healthcare facilities on appropriate time. Therefore, the women who enjoy the right to spatial mobility they can get better healthcare services than those who cannot enjoy the right.

5.11: Conclusion

From the history of human civilization, humans have tried to form family to fulfill their basic human needs and family gives the basic shelter to all social human beings. But it is also the family who deprives and discriminates human beings. In the boundary of the family, the study holistically observes women discrimination, violence against women, deprivation in the lives of women, insecurity feeling of women. But most of the time they cannot protest against all these discriminatory behavior committed by the male member of the family. They take all those happenings as their fate (*kopal*). Such internalization process facilitates to consolidate male domination over women. All these conditions have made the rural women powerless, voiceless and excluded. They have no voice, no strong opinion, and no power to protest against discrimination; it is not at all possible for women to establish their power. As a result, they even cannot get the proper healthcare facilities and enough necessary cooperation from family during their ill health condition, and crisis moments. Patriarchal family system does not give them priority in anywhere and especially in healthcare. The pattern of patriarchy ignores women much. Thus empowerment in family matters strongly correlates with the access to standard reproductive healthcare. If a woman enjoys the right in taking decisions in family matters she has more access to reproductive healthcare services. In such cases, a woman can take decisions more independently regarding her healthcare: what she should do, what should not. But such an independent decision by women hardly found in

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the rural society. Most common form of decision is compromised decision: compromise between men and women, husband and wife. But in such a compromised decision, a woman can hardly exert her expected role on decision outcomes. Rather in such a patriarchic family system, any compromised decision is naturally dominated by the male members of the family. Therefore, anthropologically speaking, reproductive healthcare for the rural women is very much dependent on women empowerment in family domain.

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Notes and References

1. Women's works are mainly confined to biological and social reproduction which includes giving birth of children and performing some household and social works.

2. It is an unwritten rule in the rural area that there is a head in every family and he is generally a male member and obeyed by all members.

3. Average family size in Bangladesh is 4.4. This figure is 4.6 in *Hazipur* which is bigger than national average.

4. Members of a family are not equally open to each other as the family authority is hierarchically ordered in rural Bangladesh.

5. For detail, Taherunnesa Abdullah, *Village Women As I Saw Them*, BARD, Comilla, 1978.

6. *Report on Sample Vital Registration Survey 2007*, BBS, Dhaka, p. 4.

7. *Ibid*, p. 4.

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Chapter 6

Social Empowerment on Reproductive Healthcare

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Chapter 6

Social Empowerment on Reproductive Healthcare

6.1: Introduction

Human being is a social being. Traditionally, social bond in rural Bangladesh is pre-dominant. Human life is very much dominated, controlled and regulated by social norms, values, beliefs, customs and traditions. Social power and patronage make differences in obtaining social services like healthcare. In this respect, gender plays a significant role—male gets more and modern healthcare and female gets less and traditional healthcare. Rural society of Bangladesh is regulated and controlled by patriarchy which allocates key social positions for men and subordinate positions for women.[1] By using social powers, men create and maintain discrimination and domination over women even in healthcare sector. Thus, social power is an instrument of securing more and modern healthcare facilities for men. Therefore, it is assumed that if women are socially empowered, they will get the healthcare services equal to men. This chapter has attempted to deal with how and to what extent women's social empowerment facilitates one to access standard reproductive healthcare. As an effort to do that some major areas of women's social empowerment has been identified and their impact on reproductive healthcare has been assessed.

6.2: Women's Social Position on Healthcare

In any society, one's social position is determined by mainly his/her economic condition, education, status, power, gender, race, caste, ethnicity etc. In the rural areas, women's social position is mainly determined by their husband's social positions as most of the women are dependent on husbands.

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In *Hazipur* village, no woman has been found as the formal leader of the society except Marium Begum who was an elected member of the Union *Parishad.* Only 3 women have been found in the village who are the informal leaders of *Hazipur* village. Other than those 3 women, all women's inferior social position is ordinary. It is clearly indicates women's social position in the rural areas of Bangladesh. In the rural areas, because of many obstacles in family and society, women cannot go beyond their ordinary lives. The first reason behind this is that women are treated as women- everywhere, at home, in society, state, school, college, university, any organization, any institution, everywhere in their lives. Women are treated as "the second sex," as inferior, as good for nothing, as invisible worker for family, society and state. Though women are not responsible for their female sex, it is a woman who suffers lifelong because of her sex. Where men are "the first sex", then obviously women are "the second sex". Female sex does not make them able to perform their duty as a formal leader of the society.

Lack of education, superstitions, social structure, family boundary, religious belief, attitude, norms, rules, regulations, rural male groups, lack of infrastructure, reproduction in different phases of life, responsibility towards family, socially constructed female behaviors as soft, calm and sensitive, male violence—all these are responsible for not making women as the formal leaders of the rural society in Bangladesh. Male attitudes to women are not positive that means male groups in rural society do not want to see women as the formal leaders of the society. As a result, they (male) hold the tradition of their rural society.

In *Hazipur* village, even the three women who are the informal leaders of the village are not much conscious about their leadership. They only perform their duty as like as very ordinary people. They are the leaders only for the women

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affairs, not for men. No man hears their anything only during any crisis period; some women come to those three informal leaders and take their suggestions. Interestingly, none of those three women are educated. None of them has reached to high school. As a result, they give suggestions to the rural women from their own thinking and experience which are not much constructive, useful and helpful.

It may be noted with importance that the Bangladesh Government has taken a number of measures aiming at empowering the rural women. Of these, the Local Government (Union *Parishad)* Second Amendment Act, 1997 is remarkable,. By this Act, a provision has been made to introduce direct election system of the seats reserved for women instead of nomination. We have intensively investigated that Marium Begum once who was elected Union *Parishad* member has no social role in reality. In addition, NGOs operation for empowering the rural women has hardly positive impact on women empowerment in the society. Rather social powers are monopolized by the male members of the society although there may have a very few exceptions.

From the above discussion, it is almost clear that women's social position in the society is very subordinate and inferior to men. Because of their sex role in society, women cannot get enough facility to assume superior position in society. Like other villages of Bangladesh, women of *Hazipur* are not able to get modern medicare facilities, doctor, nurse, health worker, medicine. Because of their inferior social position not only adult women but also female kids die each year.

6.3: Husband's Social Position on Healthcare

In the rural area of Bangladesh, social position of men is very significant. Like men, social position of husband is also significant for the rural women. In rural

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areas, professional job diversification is very rare; social position of any man is determined mainly by money. That means social position or class structure in the rural area of Bangladesh is determined by money, wealth, land etc. There are mainly two classes in the rural areas: rich class and poor class. Of course, a huge number of populations belong to middle class group. Rich class has enough money, land, wealth, property, large home, power, honor etc. On the other hand, the people who belong to the poor class have no enough money even to properly feed the members of the family, no land, no honor, no power, no medicare facilities, no property, small and poorly home, no food etc. So, for any woman in rural Bangladesh, husband's social position and also possession of property is very significant to get any type of healthcare.

In *Hazipur*, the rich people and socially dominant also have enough money; they usually go to doctors, hospitals, clinics and can buy medicine any time. Because of their powerful social status and social position, sometimes they call doctors at their homes. The wives of the rich people in *Hazipur* usually get modern medicare facilities during pregnancy period, delivery and after delivery. Rich women also stay under observation of doctor/nurse/health worker during their pregnancy period and after delivery. On the other hand, in *Hazipur* village, the wives of poor and powerless people most of the times cannot get medicare or healthcare facilities; because who usually cannot get enough food how they can get medicare or healthcare facility that is a big question as well as burning issue. Most of their (poor people) wives go to the quacks, *pir* and *faqir for healthcare*. *Pir* and *faqir* are the people who give water, oil, soil with their magical power and rural people think that those *pir* and *faqir* have very powerful insight by which they can see any disease, any problem, human's past, present and future; and they have very strong power to heal anyone and to save anyone from any type of crisis or danger or risk. Like doctor, hospital and clinic, their (*pir*, *faqir*)

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fees are not much high. As a result, poor, landless and powerless people's wives usually go to them to get healthcare even in pregnancy period and/or for their newborn babies.

Anthropologically, an interesting condition has been observed in certain cases. Generally, husband's social position is not used in getting wife's and newborn's healthcare but it is mainly and frequently used for husband's own sake. Some wives of socially powerful husbands are also deprived of the fruits of husband's social superior position. These husbands normally neglect their wives and don't take necessary care for them. This is because of patriarchic attitude and behavior of the male. Therefore, husband's superior social position does not always ensure wife's better healthcare.

6.4: Observance of *Purdah* on Healthcare

According to Islam, *purdah* is a must for all adult women to cover their bodies from outside people's eyes. *Purdah* or curtain or veil restricts women most of the times from working in outside world. The rural people prefer *purdah* for women. Mainly the rich women mostly wear *purdah* rather than the poor women; because poor women have to go outside for work many times. So, they cannot manage *purdah* always.

In rural Bangladesh, women are considered to be the repository of culture and bear the burden of shame, purity and pollution. A woman really lives and works within the boundaries of the family, *para* (compound), the nexus between shame and honor is also closely linked to their mobility outside the compound.[2] The terms shame and honor are used to characterize the behavior of women and men, but their specific meanings vary with context. Honor is seen as a male virtue in relations with one another. The term shame is a female virtue, which has

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negative as well as positive values. In the rural society, by upholding "*izzat*" (good character) and respect of the family, a man ensures female family members follow society's norms and rules.[3]

Speaking of childbirth experience is a social taboo or *lajja* for most of the rural women. Attitudes, however, are gradually changing with many more women speaking quite candidly of their feelings.[4] Notions of privacy are very culture specific and difficult to conceptualize.[5] For women, 'privacy' was linked to notions of shame. The rural women are not comfortable lying undressed on the labor table in front of unfamiliar faces.[6] Such rituals significantly determine the reproductive health behavior of the rural women of Bangladesh.

Not only the rural women but also their family members (male members) do not like to show women's undressed body in front of male doctors, male/female nurse or employee of hospital or clinic. In most cases, because of this notion of privacy, most of the rural people want rural midwife (dai, living inside the village) to perform delivery. Most of the cases, those midwives are not trained, they are unskilled, unclean and superstitious who perform their duty with a great risk. Because child delivery is the most complex and complicated stage of any woman's life; in many cases, women and children (newborn) die because of those untrained midwives. A woman of *Hazipur* describes a story:

> Chan Ali, the head of a larger family, had two wives and many children. His first wife died in burning fire with her little son. After that Chan Ali got married to Minara Begum. After 9 months pregnancy, Minara felt labor pain once and Chan Ali called a midwife living near his home. Whole day long the midwife tried to deliver the baby from the womb but failed. Rather than calling a doctor or nurse or health worker or going to hospital, Chan Ali called two more

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midwives. Those three midwives tried a lot for two days and more (more than 60 hours) but failed. They only torned up one hand and one leg of the baby from the mother's womb as they could not understand the position of the baby in the womb of the mother. Naturally, the baby died there (in the body of the mother). After few hours, the mother also died as her belly became very large with the dead baby in her belly. Chan Ali and other male members of the family buried the leg and hand of the dead baby with the mother.

The study has assessed the impact of the observance of *purdah* on other aspects of women's reproductive healthcare. Some horrible cases have been found which are directly or indirectly related with the practice of *purdah*. Even in the case of serious complications, women don't go or not permitted to go to the hospital, clinic, doctor, nurse. Of particular, some pious and conservative families are pioneers in this respect. Of course, a gradual change of such health behavior has been observed in the rural areas.

6.5: Participation in Social Gathering on Healthcare

Though urban life is very busy and there is very little scope to gather socially, but in rural life particularly in a village, almost all people of all homes know each other and sometimes they arrange some programmes to gather socially. According to the villagers, social life is very significant because society provides many areas of cooperation in their lives. In marriage, circumcision, *milad* the rural people gather socially. Women's participation in social gatherings may have positive impact on women's healthcare. That is why, we have attempted to test this hypothesis: how and what extent women's participation in social gathering exerts impact on healthcare.

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Table-6.1: Participation in Social Gathering of the Respondents

Participation in social gathering	Total	Percentage
Yes	84	25.77%
Sometimes	56	17.18%
No	186	57.06%
Total	326	100%

Source: Field data 2012

Table-6.1 presents participation in social gathering of the respondents in *Hazipur*. It shows that 25.77 percent women can participate in social gathering, 17.18 percent can participate sometimes and 57.06 percent cannot participate in social gathering.

Table-6.2: Consultation with Doctor/Nurse/Health Worker by Participation in Social Gathering Independently

Participation in social gathering	Consultation with doctor/nurse/health worker		
	Yes	No	Total
Yes	48 (57.15%)*	36 (42.86%)	84 (25.77%)
Sometimes	30 (53.58%)	26 (46.43%)	56 (17.18%)
No	64 (34.41%)	122 (65.60%)	186 (57.06%)
Total	142 (43.56%)	184 (56.45%)	326 (100%)

Source: Field Data 2012
*Percentage of column within bracket

Table-6.2 demonstrates that 53.58 percent women who sometimes participate in social gathering independently they have consulted with doctor/nurse/health worker during pregnancy; but this figure is 57.15 percent in the case of women

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who always participate in social gathering independently and 34.41 percent who do not participate in social gathering independently. On the other hand, 46.43 percent women sometimes participate in social gathering independently and 65.60 percent women do not participate in social gathering independently who did not consult with doctor/ nurse/ health worker during pregnancy. That means, participation in social gathering independently has much importance on consultation with doctor during pregnancy. The result of the chi-square demonstrates that there is a relationship between the two variables. At 5% sig. (level of significance) and 2 df. (degree of freedom) the table value is 5.99 and calculated value is 14.93 which is bigger than the table value. Therefore, the null hypothesis to be rejected, that means, there is a relationship between the two variables. In reality, consulting with a doctor is a family decision like participation in social gathering.

Photograph-6.1: Asma Begum, the Head Mistress of *Hazipur* Government Primary School but no Social Role

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Right to participation in social gathering for the rural women in Bangladesh is very restricted by a number of obstacles. Despite the fact, it has been found that the right to participation is closely associated with women's access to better reproductive healthcare. The right facilitates women to participate in the healthcare programs and activities. The study also has assessed the impact of participation on other aspects of women's healthcare and positive relations have been found in most of the cases.

We have dealt with the impact of women's participation in religious gathering on healthcare. In patriarchic rural Bangladesh, even religious gatherings are also not out of patriarchic control and domination. In major religious gatherings of Islam, women are strictly prohibited to take part. As a result, women cannot participate in those gatherings. In exceptional cases, the women who can participate in religious gatherings their healthcare conditions are not better than those of the non-participant. Therefore, women's participation in religious gatherings does not make any difference in their healthcare. Rather their traditional beliefs and practices make difference in reproductive healthcare.

6.6: Traditional Beliefs on Healthcare

Most of the rural people of Bangladesh are Muslim. Bangladesh is familiar as the Muslim majority country in the world. Therefore, Muslim culture and lifestyle are predominantly in everywhere of Bangladesh. Rural society is not different from that. Rural Bangladesh is known as more traditional and religion based area than the urban areas of Bangladesh. So, religion has great impact on everywhere of the people's lives as well as on the sector of healthcare. Similarly, women's participation in religious gathering may have impact on their healthcare.

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During fieldwork in *Hazipur*, it has been observed that the rural people basically the rural women strongly believe in Allah but interestingly most of them do not know the appropriate rules to pray five times a day and also cannot recite the holly *Quran*; but all of them told me that it is Allah who is the owner of everything. According to the rural people, "Allah gives our all children like everything of the world, so why we should use contraceptives to stop Allah's deed, it is a sin. Allah gives the children and He will give as many as He wants. It is not anything humanly work."

Still in today's modern world, many traditional people living in rural Bangladesh who do not go to doctors or hospitals or do not usually take any modern medicine because they think that Allah gives all the diseases and problems and He will cure everything. In most of the areas they prefer *kabiraj*, *pir* rather than going to doctor in the time of any disease, crisis, pregnancy; because they think that those *kabiraj* and *pir* people are very close to Allah as they are very religious persons and they have strong power to heal any one in any crisis or disease.

Case Study 1

Rahmat Ali had 5 children. At the age of 3, his youngest son Belal could not walk properly. Rahmat Ali went to nearby *kabiraj* to take some powerful healing water (*pani pora*) to get rid of this danger. But Belal did not improve rather became more and more sick. Rather than going to doctor or hospital, Rahmat Ali went to *kabiraj* home in a strong belief that *kabiraj* people are very much religious, they would heal Belal. But nothing did happen. At the age of 6, Belal even could not walk anymore. He always sat down at the home yard. After one year, it was observed that Belal could not even sit down by any way,

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he only laid down on the floor at home. By that way, after few months Belal died. Rahmat Ali did not know that Belal was attacked by "polio" which disease has vaccination. Vaccination program from government which is really free of cost and above all the disease has the modern, scientific, medical treatment. This is the traditional religious belief which was very much strong in the mind of Rahmat Ali.

Case Study 2

Rahima Begum was 40 years old who had two daughters but she has given birth of more than 11 children who died after few minutes of their birth. People told that it was the work of ghost. Each year Rahima gave birth of a child but nobody did exist even for hours. She faced over-bleeding during her delivery but did not go to the doctors or hospital rather went to nearby *kabiraj*. She and her family members believed that *kabiraj* can handle this evil work of ghost but nothing worked to her. After severe bleeding from her body for several years and giving birth of 13 children Rahima died at her 40 years age. The villager said that the ghost who affected Rahima made her very thin and weak at the time of her death.

Because of religious belief in society, many women and children also cannot get enough healthcare facilities. During pregnancy, because of some religious beliefs many women become so superstitious that they do not perform some works and do not eat some nutritious food. So, by that way religion affects healthcare in rural Bangladesh.

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6.7: Participation in *Shalish* on Healthcare

The rural society of Bangladesh has its own laws, rules, regulations and regularities. Inside the rural area they have the power to punish anyone for a crime in a particular village. That means, inside the rural area or in a particular village, a particular law enforcing committee has much power to do anything and the villagers also have to obey their (committee) laws. Sometimes the disobeying person has to face exclusion (*ak ghore*) from the whole village. He/she may live inside the village but in real sense excluded from everyone of that village. They cannot attend in any programme, any meeting, even any one of the village is not allowed to talk to that person. The law enforcing committee judges in a special meeting held inside the village area and the date and time of that meeting are disclosed to every one of the village before the meeting is held. According to the village people, this judgment meeting is called "*shalish*".[7] *Hazipur* is not an isolated village of Bangladesh. It is a typical village which represents other villages of Bangladesh in regard to the rural law enforcing committee or *shalish.* There are always one or two heads who are called the village *matabbar* or *matbar* or *morol* whose decision is law and whose rule is the last thing in a *shalish.* Very interestingly, in *Hazipur* and all other villages of Bangladesh it is hardly observed any woman as *matbar*; because this position is and was only for male people as we are living in a patriarchal social system generation after generation. Male people do not like and allow women to be the head of a *shalish* or the head of the law enforcing committee. So, it is useful to say that most of the time the judgment goes against the rural poor women as "women are the poorest of the poor" in all senses.

In the whole village, the study found only 4 women who said that they can participate in *shalish* independently. Women's absence from *shalish* clearly

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indicates women's inferior social position in rural area. Though gender and class are two significant phenomenon in rural society, women and basically rural poor women are the victim of "*shalish*"; because most of the time the judgment of *shalish* goes against the poor women which affect their familial and societal life from different points of view. In a similar way, their healthcare is also negatively affected.

Case Study 3

Rahela, now 40 years old, was not the only daughter of her father. They had 10 family members at their home. Rahela's father was a very poor and landless peasant who could not feed all of his children properly. Because of not giving any dowry, he (Rahela's father) could not manage married life for all of his daughters. During 18 years age, Rahela became engage with Fazar Ali (then 25 years), relative of a *matbor* of *Hazipur*. But Rahela could not know that Fazar Ali only wanted to physically abuse her. After few months of their relationship, Rahela became pregnant and by following other examples of the society, Fazar Ali denied the allegation. *Shalish* was called by the rural elite and even after knowing everything true about the relationship, the *matbor* and village elite punished Rahela, not Fazar Ali. Fazar Ali married elsewhere and few months later Rahela gave birth of a daughter looks like Fazar Ali. Through extreme poverty and severe insult, Rahela reared up her daughter. Few years ago, somehow Rahela could manage a groom for herself.

By that way, the rural poor women suffer a lot in the name of *shalish.* In one hand, these poor women struggle against poverty and on the other hand, they

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face the very ugly rules and laws of the rural society. These also affect their healthcare. We have found in the study area that the women who can independently join in *shalish*, generally they are also able to take decision about their health. And importantly if the judgment of *shalish* would not be against women/poor women, they might live quite happily and could live a healthy life in society. Therefore, *shalish* in the rural society of Bangladesh seems to be a means of male domination and exploitation over women particularly poor women. As a result, *shalish* does not play a positive outcome on women's reproductive healthcare and participation in the institution makes a little difference in women's healthcare.

Photograph-6.2: Asifa (16), Waiting for Marriage

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6.8: Right to Spatial Mobility on Healthcare

During pregnancy, most of the women are likely to follow social norms and rules. The prevailing influences of modern ideas and modern healthcare facilities have brought about conflicting notions between traditions and new ideologies and knowledge, thereby affecting health seeking behavior. Not only during pregnancy and just immediate after childbirth but also in any time generally. The rural women are bound not to go outside home by their own wishes even in emergency or crisis period. Most of the time, they have to take oral permission from their husbands or mother-in-laws in absence of their husbands to go anywhere. There are many rigid rules and laws on physical mobility for the rural women.

Rural people basically the rural men try to bind or try to limit the physical movement of women which affects their (women) healthcare from various sides. In times of crisis or disease, women cannot go to doctor or hospital herself, they have to wait for coming husbands or male members to home. They even cannot go outside of home to take any kind of knowledge or information about health problem from any educated women or health worker without the permission of their husbands. By that way having no right to physical mobility affects women's healthcare negatively.

It has been found that the women whose spatial mobility is unrestricted they can get better healthcare services. But this fact is not true for the poor women. As they have free mobility but no purchasing capacity to buy healthcare services. Generally the women who work outside home and/or who have unrestricted spatial mobility they have better reproductive healthcare. Therefore, with the increase in spatial mobility access to better healthcare facilities is also going to be increased in rural Bangladesh.

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6.9: Superstition on Healthcare

Regardless of religion, class, urban and rural origins, the majority of Bangladeshi people believe in the existence of a supernatural world.[8] When negative events happen in people's lives, such as deaths or illnesses, usually explanations of evil spirits and bad forces are evoked.[9] Lack of scientific knowledge and interpretation is the main cause behind such a state of affairs. Healthcare seeking behavior during pregnancy and childbirth are linked to women's own social and cultural interpretation of illness and wellbeing, and 'complication' in birth are often attributed to supernatural causes.[10]

Photograph-6.3: A Local Leader Who Dominates Even the Domain of Women

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Rural people's beliefs in ghost or spiritual things affect their daily lives from many sides. A huge number of village people firmly believe that ghosts really like beautiful young girls, women who have long and open hair, pregnant women, women who have very little children or infant just after delivery, women who travel around the village at mid-noon and after evening. So, the rural people are reluctant to permit women to go outside from home boundary alone. The women of *Hazipur* village discussed some interesting stories to me about the evil deeds of ghosts.

Case Study 4

Kulsum Begum, 50 years old, has six children but her number of pregnancies was nine that means three of her children died immediate after delivery. According to Kulsum and other women of *Hazipur* it was the work of ghost. During her pregnancy, Kulsum felt something black colored and evil thing around her. She showed other people to that evil thing but nobody could watch that, it was only she who could see. Kulsum cried loudly sensing the evil. Sometimes the ghost also touched her and told her that he (male ghost) would eat Kulsum's baby in the womb. Kulsum tried to convince the ghost not to take her child and also offered some delicious foods to the ghost. But soon after delivery her child died. The same happening happened thrice in her life.

Cast Study 5

Shahida Begum, age 40, now has three sons. During her 14 years age, she faced some ghostly works done by evil things. Shahida saw very long and black man in front of her who brought up her on trees and Shahida could not move from the tree by herself. Shahida started to

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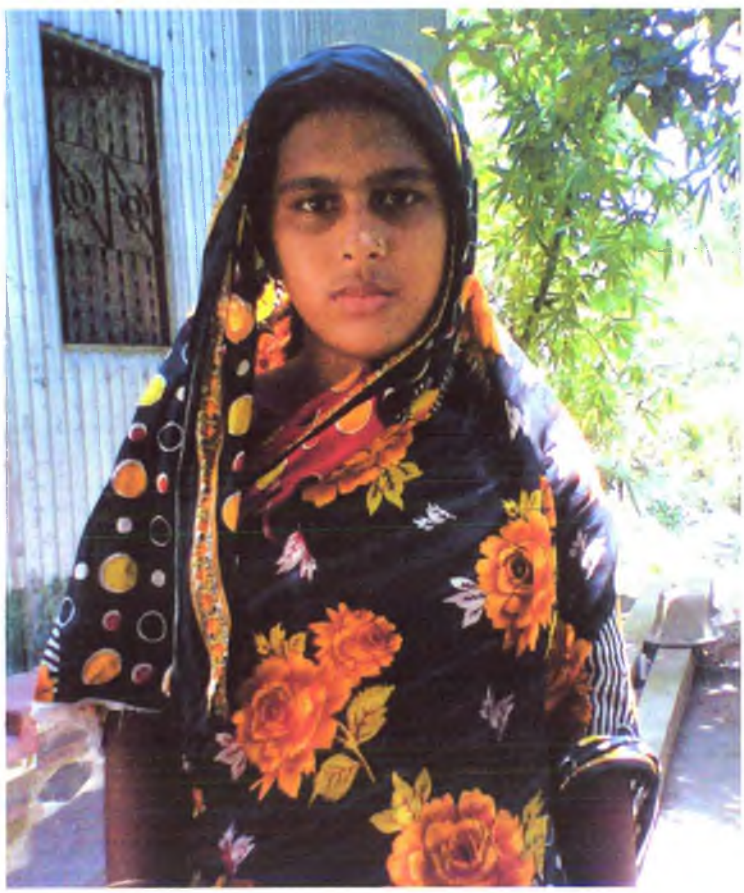
sing by herself, talked by herself, danced and also cried loudly. Her parents brought *ojha* (the doctor of ghost) to remove the ghost from her body. *Ojha* tried to do so and told her parents to arrange a marriage for Shahida. Shahida's parents did so after few months. At her early age Shahida got married and that was called *ballo bibah* (early marriage) which is a crime and bad for women's health.

Photograph-6.4: Ruma, a Victm of Early Marriage and Immature Pregnancy



Rural Bangladesh is an ideal model where women's reproductive healthcare is significantly influenced and determined by the superstitions the society hold. Rural Bangladesh is characterized by the unavailability of adequate and modern healthcare facilities. In addition, people's superstitions make the situation complicated. But with an improvement in education and consciousness, the situation is gradually changing.

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6.10: Religious Observance on Healthcare

Religion plays a significant role in the rural people's life of Bangladesh. It has been mentioned earlier that most of the people of rural Bangladesh are Muslim because they are the followers of Islam. Islam is called the religion of peace. But in some cases, Islam is very much rigid. The holy *Quran* is dedicated for men only where Allah says to men to take care of their women and women must have to cover their whole body to protect their beauty from other men. They cannot go out without "*purdah*" or curtain or veil in front of other people except their own father, brother and husband.

The concepts purity and pollution are also important to understand religious views of women. Women linked notions of pollution and seclusion to the place of delivery.[11]These notions are largely restricted to home birthing. If the place of delivery is at home, then soon after childbirth, women are usually secluded and live alone in a room called *atur ghar* (room of seclusion) for at least seven days.[12] The TBA (Traditional Birth Attendants) perform all the *nongra* or polluting jobs, which include assisting in the labor process, holding the newly born baby, removing the placenta, cleaning the blood-stained cloths of the mother, and looking after the mother and baby. It is understood that whoever comes into initial contact with a bleeding woman becomes *choa* or *napak* (polluted). These notions of blood, pollution and purity are inherent in cultural ideologies of pregnancy and childbirth in rural areas.[13] Rural people did not perceive female paramedics or the *ayahs* who are also intricately involved in the process of childbirth as *napak* (polluted). The *ayah* usually cleans the blood-stained cloths and performs all the *nongra* (perceived to be defiling) work. Ironically, as well as protecting the 'sanctity' and 'purity', the *atur ghar* tends to be the most secluded and unhygienic room in the home, usually closed, dark, and with bad ventilation. Unfortunately, cultural understandings confine women

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to an unhygienic *atur ghar* to protect their sanctity and purity, which is detrimental to their health.[14]

In *Hazipur*, religious observance has great impact on women's health and healthcare. In the village, it is observed that the people who pray five times a days, obey all or most of the rules and regulations and laws of Islam and are more rigid than the people who usually do not perform those. The religious people try to keep their women inside home and bind them with many rules; and among the rules *purdah* is the main. Even in times of danger and crisis, those women have to wear *borka* (veil) to go outside of home and cannot show their uncovered body in front of any man even in front of doctor.

Case Study 6

Kuran *Mawlana*, 55 years old, has no child. At their early age, he and his wife tried to be parents and went to the nearby *kabiraj*. Kuran *Mawlana* is an *Imam* of *Hazipur*. He believes that it is his wife who has physical problem and because of this he could not be the father of a child. But he did not go to doctor or hospital to check up his body rather he sent his wife to female *kabiraj* to take some local medicine for herself (wife). But the village people think him guilty for not being a father though he does not believe it. Only because of rigid and extreme religious attitude and observance, both he and his wife did not go to doctor, hospital or took any kind of modern medicare facilities in their whole lives.

From the above discussion, it is almost clear that religious observance has great impact on healthcare in the rural areas of Bangladesh. Because of rigid religious observance, many families do not allow their women to take scientific and modern medicare or healthcare facilities. As a result, many mothers and infants

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die each year in Bangladesh and many also face different types of complexities from which the women and their infants suffer a lot whole life. Therefore, religious observance in most cases negatively correlates with the access to standard reproductive healthcare. An important point is to note that the study deeply observes the coexistence of religion and superstition. It seems that at a certain point religion and superstition intermingle which negatively affects women's healthcare.

6.11: Membership in Social Organizations on Healthcare

As a social human being, people like to establish different types of social organizations for their social and economic needs. Among these social organizations like club, *samitee* are the main who help rural people in their crisis moments and also arrange recreational activities to develop rural people's lives. Sometimes, these rural social organizations play significant roles to remove social and familial clash and crime also. In times of economic crisis, these also help the rural people. In this part of the study, it has attempted to assess how and to what extent membership in an organization exerts impact on women's reproductive healthcare.

Table-6.3: Membership in Social Organization of the Respondents

Membership in social organization	Total	Percentage
Yes	68	20.86%
No	258	79.15%
Total	326	100%

Source: Field Data 2012

Table-6.3 presents membership in social organization of the respondents. It shows that 20.86 percent women have membership in social organization and 79.15 percent have not membership in *Hazipur*.

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Table-6.4: Number of Children by Membership in Social Organization

Membership in social organization	Number of Children			
	1-2	3-4	5+	Total
Yes	38 (55.88%)*	20 (29.41%)	10 (14.71%)	68 (20.86%)
No	174 (67.44%)	68 (26.36%)	16 (6.21%)	258 (79.15%)
Total	212 (65.04%)	88 (26.10%)	26 (7.98%)	326 (100%)

Source: Field Data 2012
*Percentage of column within bracket

Table-6.4 demonstrates that the women who have membership in social organizations 55.88 percent of them have 1-2 children, 29.41 percent 3-4 children and 14.71 percent more than 5 children. On the other hand, 67.44 percent women have 1-2 children, 26.36 percent 3-4 children and 6.20 percent more than 5 children who have no membership in social organizations. However, membership in social organizations has some effect on the number of children. The result of the chi-square demonstrates that the relationship between the two variables is not visible here. At 5% sig. (level of significance) and 2 df. (degree of freedom) the table value is 5.99 and calculated value is 6.15 which is bigger than the table value. Therefore, the null hypothesis to be rejected, that means, there is a relationship between the two variables.

Social organization not only recreates people and their economic helping hand but also make the people conscious about their health and family life. But in this context, no impact is visible.

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Table-6.5: Places of Delivery by Membership in Social Organizations

Membership in social organizations	Places of Delivery				
	Home	Hospital	Clinic	Other	Total
Yes	62 (91.18%)*	4 (5.88%)	2 (2.94%)		68 (20.86%)
No	206 (79.84%)	38 (14.73%)	12 (4.65%)	2 (0.78%)	258 (79.15%)
Total	268 (82.21%)	42 (12.88%)	14 (4.29%)	2 (0.61%)	326 (100%)

Source: Field Data 2012
*Percentage of column within bracket

Table-6.5 demonstrates that the women who have membership in social organizations 91.18 percent of their deliveries have taken place at home. On the other hand, this figure is 79.84 percent who have no membership in social organization. It means, membership in social organizations in a village like *Hazipur* plays some roles on the places of delivery. The result of the chi-square demonstrates that there is a relationship between the two variables. At 5% sig. (level of significance) and 3 df. (degree of freedom) the table value is 7.81 and calculated value is 12.89 which is bigger than the table value. Therefore, the null hypothesis to be rejected, that means, there is a relationship between the two variables.

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Table-6.6: Nutritious Food Taking During Pregnancy by Membership in Social Organizations

Membership in social organizations	Nutritious food taking during pregnancy			
	Yes	Partial	No	Total
Yes	8 (11.78%)*	24 (35.30%)	36 (52.95%)	68 (20.86%)
No	34 (13.18%)	132 (51.17%)	92 (35.66%)	258 (79.15%)
Total	42 (12.89%)	156 (47.86%)	128 (39.27%)	326 (100%)

Source: Field Data 2012
*Percentage of column within bracket

An attempt has been made to assess to impact of membership in social organizations on taking nutritious food during pregnancy. Table-6.6 shows that the women who have membership in social organizations 11.78 percent of them have taken nutritious food regularly during pregnancy. On the other hand, this figure is 13.18 percent who have no membership in social organizations. That means, membership in social organization has little visible effect on taking nutritious food during pregnancy. The result of the chi-square demonstrates that there is a relationship between the two variables. At 5% sig. (level of significance) and 2 df. (degree of freedom) the table value is 5.99 and calculated value is 6.97 which is bigger than the table value. Therefore, the null hypothesis to be rejected, that means, there is a relationship between the two variables.[11] Of course, food in the rural society is distributed by the norms, rules and regulations of the family.

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6.12: Conclusion

Women's health status is not only vulnerable in Bangladesh; they have also socially been left far behind. Women's social status and power determines their health status to some extent. Women in rural areas are burdened with lower literacy rates, poorer economic conditions, lower social status, oppressive social customs and understandings and above all poor healthcare services. Male attitudes and behaviors to women are also responsible for negligible healthcare of women. Lower social position, observance of *purdah*, lack of participation in social gathering, lack of participation in *shalish*, religious observance, lack of right to physical mobility, lack of membership in social organization etc are responsible for rural women's lives not to get proper and modern healthcare facilities. The study clearly demonstrates that the rural women are socially deprived, victimized and excluded from various entitlements. They cannot hold any social positions by which standard healthcare for women might be ensured. Rather some social rules, regulations, customs, values, beliefs negatively affect women's healthcare. Particularly, women's reproductive healthcare is a socially neglected phenomenon. As a result, lack of social power and patronage, malpractice of societal forces make standard reproductive healthcare inaccessible for the rural women of Bangladesh.

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Notes and References

1. Patriarchy is the system of domination of men over women, a mechanism to consolidate and continue male domination over women in every sphere of life.
2. Sattar A. Huq N; Marriage: Through the Eyes of Adolescent Girls; BRAC Research Report. Health Studies, 1992, p.
3. Blanchet Therese; *Lost Innocence, Stolen Childhoods*; Dhaka: The University Press Limited, 1996, p.20.
4. Afsana Kaoser and Rashid Faiz Sabina. *Discoursing Birthing Care: Experiences from Bangladesh,* The University Press Limited, Dhaka, 2000, p. 40.
5. *Ibid*, pp. 49-50.
6. *Ibid*, pp. 49-50.
7. *Shalish* is an informal judiciary system in rural Bangladesh. It is comprised mainly by the elderly male people of the society.
8. Rozario S; Parity and Communal Boundaries: Women and Social Change in a Bangladeshi village; Sydney, Allen and Unwin; 1992, p.
9. Afsana Kaosar and Rashid Faiz Sabina, *op. cit.*, p. 28.
10. *Ibid*, p. 28.
11. *Ibid*, pp. 38-40.
12. *Ibid*. pp. 38-40
13. *Ibid*, pp. 38-40.
14. *Ibid*, pp. 38-40.

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Chapter 7

Economic Empowerment on Reproductive Healthcare

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Chapter 7

Economic Empowerment on Reproductive Healthcare

7.1: Introduction

Economic power is so vital that it makes easy for one's access to all social services including healthcare. One's position in society, family and state is largely determined by his/her economic achievements. A self dependent human being can take any decision independently and can consume social services. On the other hand, economically dependent one cannot take independent decision even about his/her healthcare. It is because of the fact that healthcare decision is very much involved with economic matters. In particular, the rural people of Bangladesh are poor and women are the poorest of the poor. Most of the women are engaged in household work which is a non-paid sector. Women's works are not socially recognized as economic ones, rather these are considered reproductive works.[1] As a result, women are treated economically dependent and their position in family and society are also determined as subordinate. As an economically dependent and non-economic member of the family, women cannot get proper treatment even in reproductive healthcare. It seems that economic empowerment would enable women to have proper reproductive healthcare. Therefore, this chapter deals with how and to what extent women's economic empowerment facilitates to access to standard reproductive healthcare available in the society.

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7.2: Income Dependency on Healthcare

Nature of self-reliance or dependency in terms of income may have significant impact on healthcare. It may be assumed that a self-reliant woman can take any decision independently most of the time even about her healthcare. On the other hand, economically dependent woman cannot take any decisions including about her healthcare. Data from the research field reveals that an absolute majority (92.64%) respondents in the rural area are economically dependent on men particularly husband and/or father-in-law. They do not have any particular and separate income of their won. Patriarchal society of Bangladesh does not recognize household work as an economic or productive work rather treated as reproductive one. Only earning cash money is considered as economic work but domestic work is not treated as same economic. However, defining women's works in this way certainly undermines their position in family.

Photograph-7.1: A Woman Helps Earning Cash Money but no Recognition

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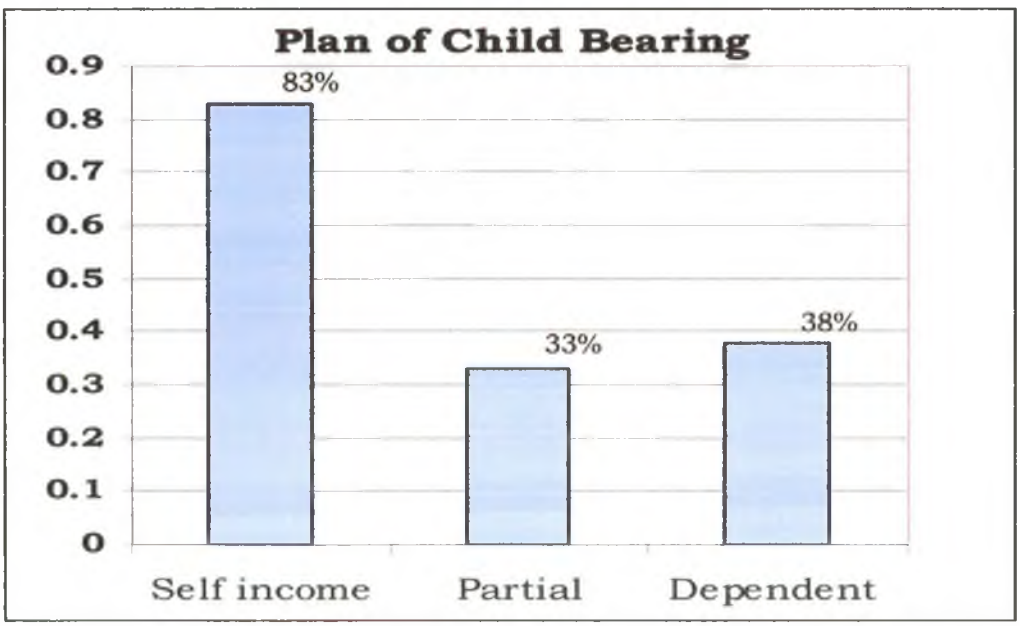
Data demonstrates that significant correlation exists between self-reliance in terms of income and reproductive healthcare. The respondents who are self-reliant have less number of children than those who are dependents.[2] At the same time, the self-reliant respondents' places of delivery are hospitals or clinics more in number than that of the dependent ones. Similarly, in all other indices of healthcare, the self-reliant respondent group is in more advantageous conditions. Therefore, a positive relation between the two variables is visible. But the question is: why not very strong relationship exists between the two variables. Perhaps the most appropriate answer to this question is that even a self-income woman has no effective control over her won income which will be clearer from the subsequent analysis.

Graph-7.1: Plan of Child Bearing by Self Income or Dependent



Source: Field Data 2012

Graph-7.1 demonstrates that in *Hazipur* village, the women who are self-dependent or have self-income 83.00 percent of their child bearing is planned. On the other hand, this figure is 33.00 percent who have partial income and 38.00 percent who are economically dependent. On the other hand, the women

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who have self-income 17 percent of whose child bearing is not planned partial income 67.00 percent and dependent women 62.00 percent. That means, more number (83.00%) of respondents' child bearing is planed who belong to self-income group. And less number (62.00%) of respondents belong to dependent and partial income groups whose child bearing in unplanned. It clearly indicates that income dependency has much importance on rural women's reproductive healthcare.

According to many social scientists and general observers also, in today's modern, civilized, individualistic society, every single thing is commodity. The nature of commodity is in general sense that it is an object and humans purchase the commodity by a value and this value is obviously in cash money. Many people say that today's profit and capital oriented society makes human being very much self-centric, greedy and unfair for money. According to them, in this modern world everything is purchasable including love, affection and the social services. If one has enough money then he/she can buy anything from any one. That means, the people who have money can buy healthcare anytime from anywhere. Therefore, money is almost consequently related to healthcare. That is why, it is called, "health is wealth and wealth is health."[3] This seems true for the rural women of Bangladesh. The women in rural area also who have more money and self-dependent, can get proper medicare facilities. Self-dependency has importance on planning of child bearing and by the way self-dependency most of the time makes anyone conscious about herself/himself. Self-dependent women can buy the services of doctors/health workers and can also buy contraceptives to control child birth.

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Table-7.1: Respondent's Income or Dependent on Husband

Self-Income or Dependent	Total	Percentage
Self-income	12	3.69%
Partial	12	3.69%
Dependent	302	92.64%
Total	326	100%

Source: Field Data 2012

Table-7.1 presents respondent's income or dependency on husband. It demonstrates that 3.69 percent women have self-income, 3.69 percent women have partial income and 92.64 percent women are dependent on their husband in the research area.

Table-7.2: Consultation with Doctor by Respondent's Income or Dependent on Husband

Self-Income or Dependent	Consultation with doctors		
	Yes	No	Total
Self-income	8 (67.67%)*	4 (33.34%)	12 (3.69%)
Partial	10 (83.43%)	2 (16.67%)	12 (3.69%)
Dependent	124 (41.06%)	178 (58.95%)	302 (92.64%)
Total	142 (43.56%)	184 (56.44%)	326 (100%)

Source: Field Data 2012
*Percentage of column within bracket

Table-7.2 shows that the women who are economically self-dependent 67.67 percent of them, 83.34 percent who have partial income and 41 percent who have no income consulted with doctor during pregnancy. On the other hand,

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33.34 percent women who belong to self-income group did not consult with doctor/nurse health worker at the time of pregnancy, and 58.95 percent women are dependent who did not consult with doctor/nurse/health worker during pregnancy. That means self-income and dependency of women have much impact on consultation with doctor during pregnancy. The result of the chi-square demonstrates that there is a relationship between the two variables. At 5% sig. (level of significance) and 2 df. (degree of freedom) the table value is 5.99 and calculated value is 11.11 which is bigger than the table value. Therefore, the null hypothesis to be rejected, that means, there is a relationship between the two variables. The women who earn money by themselves, can go to hospital/clinic to consult with doctor/nurse/health worker during pregnancy. It has been mentioned earlier that the women who have money or self-income, can buy or purchase healthcare or medicare facilities anywhere and anytime irrespective of caste, class, ethnic group, age, social power, social position, status, religion etc. because self-income plays a very vital role in decision-making in any family both in rural and urban areas. Amena Begum (40) states her story in the following way:

> My husband is a poor farmer living on agriculture. My father was also a poor peasant as well. My father could not feed properly all of our family members (9 members). We could not get enough food, dress and toys. There were some rich families in our village. The children of those rich families played with their toys and we all brothers and sisters looked at the scene from far away. My mother accumulated some money for many days which was very little amount and bought some necessary things for our family members. So, there was no question about healthcare in our life. And just look at me. I am also following the path of my mother because my husband is also as poor as

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my father. I have 5 children and cannot feed them with *valo mondo* (good and nutritious curry food). So, following my mother I usually gather very few amount of money for in times of crisis. Though my husband is the only member in the family who earns, he cannot properly bear the family's expense always. As a result, though I know that it is important to consult with doctor during pregnancy, but cannot afford it; because I have no money.

7.3: Profession on Healthcare

Profession is very much significant for anyone livelihood. The study defines profession or employment by various ways which are — paid, unpaid, visible, invisible, governmental, non-governmental etc. It is observed a great trend in urban women to join in income generating work both in governmental and non-governmental sectors. In this context, women get their economic freedom and independence which increase their empowerment and confidence levels and widen the places of decision-making both at home and outside.

Till today the rural women are far beyond from income generating work. From sunrise to sunset those rural women become engaged in household activities which are unpaid and invisible. The household activities include—cook and prepare food for all family members, take care the old aged people and children at home, dusting the home, cleaning and washing clothes, feed the pet animals at home, take care of those animals and above all reproduce children. But all those works are unpaid and invisible. Even the rural women who manage all the works a day long, they also believe that these are not works in fact. During fieldwork in *Hazipur*, I asked women about their professions. Most of those are housewives that mean they do all the household works. But those women replied in the following way:

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"No, I do not do anything, but my husband does, he is a farmer."

From the above quotation, it can easily be understood about the realization of women and position about their household works. Both men and women in rural areas think household activities as 'invisible' because it is unpaid. The rural women they themselves do not think their work as 'work'. Therefore, women's traditional profession (house holding) negatively correlates with women's reproductive healthcare. On the other hand, the rural women who are employed in modern and paid works they have more access to better reproductive healthcare.

Photograph-7.2: A Woman Collecting Fuel but Unrecognized

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The study has dealt with the impact of husband's profession on women's reproductive healthcare. It has been found that the husbands who are employed in other sectors like service and business, their wives generally get better healthcare services. On the other hand, the husbands who are employed in traditional professions like agriculture, their wives get below standard healthcare services. Of course, not only profession but other factors are also involved here like, higher income, better education/status and power, as well as social consciousness and so on.

7.4: Family Income on Healthcare

Family income is a very significant factor in dealing with anyone's social service like healthcare; because all families cannot afford this service despite their willingness to afford. In order to do that purchasing capacity is an important consideration. Therefore, an attempt has been made in this study to judge the impact of family income on women's reproductive healthcare.

Table-7.3: Respondent's Family Income (Annual in Tk)

Family Income (Annual in Tk)	Total	Percentage
+ 10,000	14	4.30%
10,001-30,000	30	9.21%
30,001-50,000	36	11.05%
50,001-70,000	52	15.96%
70,001-90,000	66	20.25%
90,001-110000	96	29.45%
110000+	32	9.82%
Total	326	100%

Source: Field Data 2012

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Table-7.3 presents respondent's family income in a year. It shows that only 4.30 percent women have only 10,000 plus income in a year and the highest number of women belongs to 90,001-110000 income group and their number is 29.45 percent.

Table-7.4: Consultation with Doctor on the Basis of Family Income (Annual in Tk)

Family Income (Annual in Tk)	Consultation with Doctor		
	Yes	No	Total
+ 10,000	10 (71.43%)*	4 (28.58%)	14 (4.30%)
10,001-30,000	18 (60.00%)	12 (40.00%)	30 (9.21%)
30,001-50,000	14 (38.89%)	22 (61.12%)	36 (11.05%)
50,001-70,000	12 (23.08%)	40 (76.93%)	52 (15.96%)
70,001-90,000	18 (27.28%)	48 (72.73%)	66 (20.25%)
90,001-110000	54 (56.25%)	42 (43.76%)	96 (29.45%)
110000+	16 (50.00%)	16 (50.00%)	32 (9.82%)
Total	142 (43.56%)	184 (56.45%)	326 (100%)

Source: Field Data 2012
*Percentage of column within bracket

Table-7.4 demonstrates that family income of the rural women has not much significant impact on taking or receiving healthcare facilities such as consultation with doctor/nurse/health worker during pregnancy. The result of the chi-square demonstrates that there is a relationship between the two variables. At 5% sig. (level of significance) and 6 df. (degree of freedom) the table value is

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12.59 and calculated value is 30.85 which is bigger than the table value. Therefore, the null hypothesis to be rejected, that means, there is a relationship between the two variables. The respondents of all income groups almost equally consulted with doctor/nurse. It reveals that consultation with doctor/nurse does not depend only on family income rather other factors are also involved. Of these, social and familial norms and traditions, intention of male head of the family, availability of healthcare services, and so on. As a result, family income does not exert expected impact on women's reproductive healthcare.

Table-7.5: Taking Nutritious Food on the Basis of Family Income (annual in Tk)

Family Income (Annual in Tk)	Taking Nutritious Food			
	Yes	Partial	No	Total
+ 10,000	2 (14.29%)*	8 (57.15%)	4 (28.58%)	14 (4.30%)
10,001-30,000	6 (20.00%)	20 (66.67%)	4 (13.34%)	30 (9.21%)
30,001-50,000	4 (11.12%)	18 (50.00%)	14 (38.89%)	36 (11.05%)
50,001-70,000	2 (3.85%)	12 (23.08%)	38 (73.08%)	52 (15.96%)
70,001-90,000	4 (6.07%)	30 (45.46%)	32 (48.49%)	66 (20.25%)
90,001-110000	16 (16.67%)	54 (56.25%)	26 (27.09%)	96 (29.45%)
110000+	6 (18.75%)	16 (50.00%)	10 (31.25%)	32 (9.82%)
Total	40 (12.27%)	158 (48.47%)	128 (3.279%)	326 (100%)

Source: Field Data 2012
*Percentage of column within bracket

Table-7.5 demonstrates the relationship between family income and taking of nutritious food during pregnancy. Data shows that there is a positive relation between the two variables. The result of the chi-square also demonstrates that

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there is a relationship between the two variables. At 5% sig. (level of significance) and 12 df. (degree of freedom) the table value is 21.026 and calculated value is 48.94 which is bigger than the table value. Therefore, the null hypothesis to be rejected, that means, there is a relationship between the two variables. It seems that the distribution of food in the family is regulated by patriarchic rules and regulations prevailing in the rural society of Bangladesh. The patriarchic rule always favors male members of the family in the distribution of food irrespective of families' economic background. Male members particularly income-earning male members get more food and more nutritious food of the family. Generally, male and children get the priority in the process of distributing food and then female members. If there is any food shortage women have to take the burden.

Table-7.6: Places of Delivery on the Basis of Family Income (annual in Tk)

Family Income (Annual in Tk)	Places of Delivery				
	Home	Hospital	Clinic	Other	Total
+ 10,000	12 (85.72%)*	2 (41.29%)			14 (4.30%)
10,001-30,000	28 (93.34%)			2 (6.67%)	30 (9.21%)
30,001-50,000	30 (83.34%)	6 (16.67%)			36 (11.05%)
50,001-70,000	46 (88.47%)	6 (11.54%)			52 (15.96%)
70,001-90,000	51 (77.27%)	9 (13.64%)	6 (9.09%)		66 (20.25%)
90,001-110000	74 (77.09%)	14 (14.59%)	8 (8.34%)		96 (29.45%)
110000+	17 (53.13%)	11 (34.38%)	4 (12.5%)		32 (9.82%)
Total	258 (79.14%)	48 (14.73%)	18 (5.53%)	2 (0.62%)	326(100%)

Source: Field Data 2012
*Percentage of column within bracket

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Table-7.6 demonstrates that family income has little impact on the places of delivery; because delivery at home in fact is not related with much money but the cost of hospital or clinic is much for delivery. It has been observed in the research area that the rich families generally avail of the service of hospital/clinic for delivering their pregnant women. On the other, the poor families do not have the financial capability to afford the service. The result of the chi-square also demonstrates that there is a relationship between the two variables. At 5% sig. (level of significance) and 18 df. (degree of freedom) the table value is 28.86 and calculated value is 35.73 which is bigger than the table value. Therefore, the null hypothesis to be rejected, that means, there is a relationship between the two variables. But we have found a number of exceptions to this general practice. Some rich families hardly go to hospital/clinic for delivering their pregnant women. It seems that the rich but less educated, of traditional profession and conservative outlook families normally do this practice.

In addition to these, we have attempted to assess the impact of family income on other aspects of women's reproductive healthcare but found very little positive association between the two variables. In reality, other factors apart from family income are dominant determinants of women's healthcare. Particularly, the rural familial and social rules govern women's reproductive healthcare.

7.5: Self Income on Healthcare

We the social human beings are living in modern world where everything has its own value and everything can be bought by money. So, money is very much significant object in everyone's life wherever she/he lives in. The individual person who has enough incomes or who possesses enough money can buy anything with that money. Income less or moneyless person has in fact nothing. Not only in society, in the family boundary also he/she is neglected by others.

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Income-less person has no voice in the society and even in the family. During any disease or any kind of problem, she/he may fall into great trouble if anyone does not support financially.

Bangladesh is one of the poorest countries of the third world. The people living here most of them are very poor with below U$ 1,000 per capita. In addition, a huge income disparity has thrown most of the people below poverty line. This is also the most densely populated area in the world. The density of population in Bangladesh is 964.42 per square kilometer. Therefore, the subsistence level income of most of the inhabitants of Bangladesh makes adequate and standard healthcare services impossible and unattainable.

Photograph-7.3: Cooking, an Unpaid and Unrecognized Job

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In this male dominated patriarchal society, the rural women live in the worst condition; they are the poorest of the poor. In this country, per capita income of the population is very low, income of rural people is lower than the urban people, and rural women's income is many times lower than the rural men. The person who has income he/she has power and voice in the family decisions. So, the women who earn by themselves have some voices in family matters. The women who have self-income or who have sufficient family income can take proper healthcare for herself and for her infants/newborn babies. They can take nutritious food during pregnancy, can consult with doctor/nurse/health worker during pregnancy, can go to hospital/clinic for delivery, and can buy contraceptives to control birth rate. So, self-income or sufficient family income may have much significant impact on women's healthcare.

It has been found in the research field that family income and/or self-income do not significantly correlate with women's reproductive healthcare. Even a self-income woman has no voice on healthcare decisions of the family. From overall investigation, it seems that an income earning woman has no effective and meaningful control over her self-income rather it is controlled by the male head of the family. Having no or little control over family expenditure including health sector even an income earning woman cannot get proper healthcare.

7.6: Possession of Property on Healthcare

In rural Bangladesh, land is the most important key resource as agriculture is the main source of livelihood. Most of the rural people are engaged in agriculture and they need land badly. So, in the rural society land is counted with great importance everywhere. The rural people who are directly engaged in land for producing crops are called farmer or peasant. In the rural area of Bangladesh, it

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is observed mainly three categories of peasants who have: (1) enough land and property and they hire other people in their own land to produce crops but they themselves are not involved with physical labor; they are the rich peasants; (2) the peasants who have small amount of land and invest their own labor and energy to produce crops in their own agricultural land, and they are called marginal farmers; (3) the poor peasants who have no land at all and invest their labor on others' land and they are called the landless peasants.

In Bangladesh, the ownership of women on land or other key resources is very limited. According to Hindu law, daughter can not inherit any land from her parents. In Muslim society, two daughters get the property equal to a son that means two daughters is equal to one son in inheriting paternal property. But in many cases we find that fathers deprive their daughters and give all properties to sons. To many men and even also women, daughters are the guests of father's family, after marriage they go to their husband's home which home is considered as a 'woman's own home'. But in real situation, husband's home in not anyone's own home because at that home a woman is more neglected, deprived, discriminated, and attacked with violence. After the death of husband, a woman is dependent on her son. Women's dependency on men is a life-long process from where women cannot and do not come out.

Case Study

Shamsher Ali, 70 years old, is a landlord of *Hazipur* village who has four daughters and two sons. He has two houses and huge land and property. He is an educated person and was engaged in a government job for many years. But he does not like his daughters because they are women. From their early childhood, those girls were deprived of love and affection and care of their father. Shamsher Ali gave all of

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his property including land, houses, resources etc to his two sons. Interestingly, Shamsher Ali, though he is a landlord, many people go to him and he advises and even sometimes pressurizes some people to give their property to their sons. Those men also did it and their daughters are now suffering like the daughters of Shamsher Ali. Those daughters could not get anything from father and because of only this reason at their in-laws homes they are neglected as they are neglected by their own father.

Case Study

Korimon Begum, age 50, has 5 children and her husband is not much solvent rather he is a poor peasant of *Hazipur* village. Korimon's father had some lands and he distributed those lands among his 7 children according to the Muslim law. Now, Korimon's father is dead and also her mother. Her two brothers with their wives and children are living at the home of Korimon's father. Her father died 10 years ago but till now she does not want to possess her property according to the will of her father. Korimon thinks that if she takes her share of the property, she won't go to her parental home anymore because if she takes the property, her brothers and their wives would be very unhappy and would not allow Korimon at their home. According to her 'to get *babar bari rador* (take care of father's home), I do not want to take the share of the property though I need some more property. But now, I can at least see my father's home, this is enough for me.

Given the present conditions of property ownership and inheritance system it can easily be understood women's inheritance position in the family and society. We have assessed the impact of such resourceless condition of women on various

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aspects of reproductive healthcare. It has been found that women's resourcelessness is the main cause of their ill-health, malnutrition and low standard reproductive healthcare. Even fertility and mortality rate of the rural women is also very closely related with such resource lesscondition.[4]

7.7: Control over Self Income on Healthcare

Self-income is a very important element in anyone's life both in rural and urban areas. Self-income may have significant impact on determining one's position or role in the society, family decisions and healthcare. Family income in the rural economy in considered as the income of male members although female members have a lions contribution to the income either visible or invisible. As a result, most of the women are deprived of due sharing in family income even they do not have any sense of sharing in the family income. Rural women as a paid worker get very little amount of money and most of the time their income is not sufficient for their poorly livelihood. During my fieldwork in *Hazipur*, the working (paid) women talk to me very openly and most of them answered to my question that they have little control over their own income. If husband wants the money, a woman cannot say "no" to him. If a woman says "no" she is severely oppressed and suppressed by her husband. In some cases, we have found that the poor women are entitled to borrow money from NGO, but they have no control even over such borrowed money. They earn money anyhow but their husbands spend the money. It has been found that control over self-income has very positive impact on women's reproductive healthcare.

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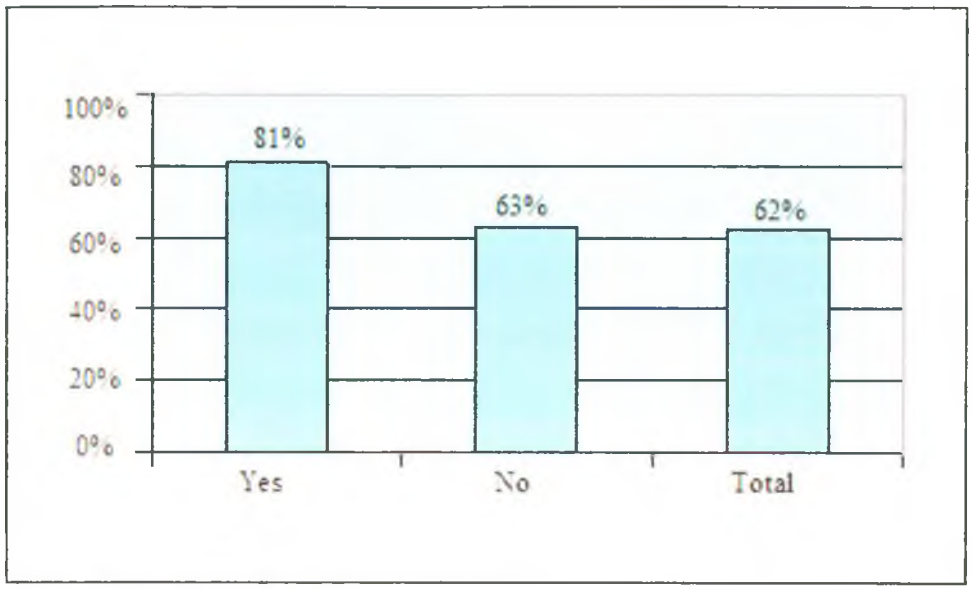
Graph-7.2: Number of Children by Control over Self Income



Source: Field Data 2012

Graph-7.2 demonstrates that the women who feel that they have control over self-income 81.00 percent of them have 1-2 children and the women who feel that they have no control over self-income 63 percent of them have 1-2 children. Field data further demonstrates that the women who feel that they have control over self-income, 14.00 percent of them have 3-4 children and 5 percent have more than 5 children. On the other hand, the women who feel that they have no control over self-income, 29.00 percent of them 3-4 children and 8.00 percent more than 5 children. It is clear that a huge number of respondents (81.00 percent) have only 1-2 children and they feel that they have control over their own incomes. The respondents who have control over their own income they have also voice and opinion about the number of children to be given birth. So, obviously there is a close relationship between number of children and feeling of control over self-income.

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Table-7.7: Control over Self Income of the Respondents

Control over self-income	Total	Percentage
Yes	42	12.89%
No	284	87.11%
Total	326	100%

Source: Field Data 2012

Table-7.7 presents control over self -income of the respondents. It shows that 12.89 percent women have control over self- income of the respondents and 87.11 percent women have not control over self-income.

Table-7.8: Consultation with Doctor by Control over Self Income

Control over self-income	Consultation with doctor		
	Yes	No	Total
Yes	32 (76.20%)*	10 (23.81%)	42 (12.89%)
No	112 (39.44%)	172 (60.56%)	284 (87.11%)
Total	144 (44.18%)	182 (55.83%)	326 (100%)

Source: Field Data 2012
*Percentage of column within bracket

Field data (Table-7.8) demonstrates that out of total 326, 42 (12.89%) respondents feel that they have control over self income. On the other hand, 284 (87.11%) respondents feel that they have no control over their own incomes. Table-7.8 shows that the women of *Hazipur* who feel that they have control over self-income 76.20 percent of them consulted with doctor during pregnancy. 23.81 percent could not consult with doctor/nurse during pregnancy. On the other hand, the women who have no control over self-income 39.44 percent of

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them consulted with doctor and 60.56 percent not consulted with doctor/nurse/health worker during pregnancy. It means that the women who feel that have control over self-income higher number of them consulted with doctor during pregnancy. The result of the chi-square also demonstrates that there is a relationship between the two variables. At 5% sig. (level of significance) and 1 df. (degree of freedom) the table value is 3.84 and calculated value is 20.01 which is bigger than the table value. Therefore, the null hypothesis to be rejected, that means, there is a relationship between the two variables. The women who have control over their own income, they have voice in family decisions and healthcare, they can go to doctor, hospital, clinic during their diseases. So, there is a close relationship between women's feeling about control over self-income and consultation with doctor/nurse/health worker during pregnancy.

Table-7.9: Places of Delivery of the Respondents by Feeling of Control over Self Income

Feeling of Control over Self income	Places of Delivery				
	Home	Hospital	Clinic	Other	Total
Yes	28 (66.67%)*	12 (28.58%)	2 (4.77%)		42 (12.89%)
No	240 (84.51%)	30 (10.56%)	12 (4.23%)	2 (0.70%)	284 (87.11%)
Total	268 (82.21%)	42 (12.88%)	14 (4.29%)	2 (0.61%)	326 (100%)

Source: Field Data 2012
*Percentage of column within bracket

Table-7.9 demonstrates that the women who have control over self-income 66.67 percent of their deliveries have taken place at home, 33.35 percent women's

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deliveries have taken place other than home. On the other hand, the women who have no control over self-income 84.51 percent of their deliveries have taken place at home and rest of the deliveries have taken place outside home like hospital and clinic. So, from the above discussion it seems to be clear that there is a close relationship between control over self-income and places of delivery. The result of the chi-square also demonstrates that there is a relationship between the two variables. At 5% sig. (level of significance) and 3 df. (degree of freedom) the table value is 7.81 and calculated value is 12.25 which is bigger than the table value. Therefore, the null hypothesis to be rejected, that means, there is a relationship between the two variables.

7.8: Right to Loan and Expenditure on Healthcare

Right to loan and expenditure of family finance may have impact on women's healthcare. Because it may be assumed that this type of right is related with financing of a family's health sector. And a family's healthcare decision is an integral part of expenditure decision in the rural areas of Bangladesh. Making loan is frequent among the rural people. Not always it is very large amount of money, rather small amount of money, like half kg rice, any kind of food, curry, cloth etc. All these things are included in the category of loan. Sometimes the rural people also take some amount of money as a loan from the rich people of the village. But for the above mentioned little things, the poor village people generally go to other poor people that means equal to their own status level. But in times of great necessity (large amount) those poor people do not go to the people like them rather they prefer to go to rich people, landlord, *matbor*, rich peasant, rich businessman to take loan. The poor people of the rural area usually take large amount of money as a loan in times of daughter's marriage to give dowry to the groom, to cultivate their own land, in times of dangerous or risky

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disease, to open up small business like shop etc. After all, taking loan is much frequent and common phenomenon in the village area.

In rural Bangladesh, it is generally observed that poor women usually do not go to men for taking loan and women in general do not take large amount of money as a loan. Women usually go to women for taking loan (money or small things). Rural women most of the times take loan from *samitee* where the NGOs operate and they are the active members of the groups. But the rule of *samitee* is to give loan to poor women for a certain time period and in the meantime women have to pay back the loan to that *samitee*. Otherwise, the *samitee* can take any action like *samitee* can collect the pet animals of the women and can roughly pressurize on the women, and other punitive measures.[5]

In *Hazipur* village, most of the women are housewives that means they are engaged in day long household activities like cooking, cleaning the house, washing clothes, taking care of old people and children and also husband and all the family members, feed the pet animals. However, to do those above mentioned works, women sometimes need extra money to manage their household as well as personal activities. Surprisingly true, men do not give money to women to bear the expenses of household activities, to buy any household necessary things. Most of the women of *Hazipur* told that in fact they have no right to loan and expenditure. If they wish to buy anything or feel necessity for anything, they have to take money from men. Otherwise, they have to collect money from their various sources to accumulate and saving by her since long period. Usually the rural women save a small amount of money by selling eggs of their pet hen or duck at home.

In most cases, male members of the household cannot know about the hidden money. Sometimes the poor women buy *shari*, *churi*, ornaments or some kind of desirable goods by that hidden saving money. But to buy those things they do

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not go outside of the home because they are not allowed to go markets. Hawkers are available in the rural area to sell their goods. From the hawkers, the rural women buy their desirable goods.

From the information it reveals that the rural women have very little capacity to make a loan except from NGOs, close relatives and neighbors. But in regard to family expenditure which is considered the most vital and strategic decision of a family women have no access into market in real sense. They have to depend on male head of the family and/or husband. Therefore, condition in family expenditure decision in the study village as well as rural Bangladesh situation is more vulnerable to women rather than men.

7.9: Conclusion

The empowerment of women in economic domain is considered as the most vital element considering the magnitude of socio-economic conditions in the family, society and state which reflects the vulnerability of women. This condition has also serious negative effect on women's healthcare. It reveals that the rural women are deprived/oppressed as well as suppressed. They have no real control over the family income and expenditure decisions. The works of house holding in which most of the rural women are engaged in is not socially recognized and not paid for that. Surprisingly, the women who earn cash money and have self-income independent from family income even they have no control over their won income. All these conditions make the women nonproductive and dependent members of the family, and make them powerless and voiceless in regard to family expenditure decisions. Therefore, economic empowerment is a vital prerequisite for women empowerment as well as accessing to standard reproductive healthcare.

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Notes and References

1. It covers both biological production and social reproduction which includes giving birth of children, take care of child, household works and social networking.
2. Previous studies also demonstrate positive relation between economic dependency and higher fertility rate. For detail, Alia Ahmad, *Women and Fertility in Bangladesh*, Sage Publications, New Delhi and London, 1991, p. 31.
3. Siddiqure Rahman Osmani, "Arthonaitik Probridhi" Daridro Mochon: Eden Somperker Sharap Nea Kichu Bhaban", in Rushidan Islam Rahman (ed.), Daridro O Unnayan: Prekhapat Bangladesh, BIDS, Dhaka, 1997, p. 15.
4. Ahmad, *op. cit.* p. 30.
5. NGOs establish *samitee* with the women of *Hazipur* but the terms and conditions of borrowing and collecting NGOs loan are very rigid.

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Chapter 8

Political Empowerment on Reproductive Healthcare

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Chapter 8

Political Empowerment on Reproductive Healthcare

8.1: Introduction

Politics deals with the distributive system of social resources. Lasswell's *Politics: Who Gets,* What, *When, How (1950)* is the central theme of politics.[1] Political power enables one to get the social services and powerlessness deprives one of getting such facilities. Therefore, distribution of social resources and services largely depends on the possession of political power. As Amartya Sen opines that health is a political phenomenon.[2] In the distribution of health services, the powerful get more and powerless get less. Rural Bangladesh is virtually apolitical. The rural people participate in politics seasonally and that is why they are called seasonal participants.[3]Particularly, the rural women are very much apolitical and apathetic to politics. Such a state of affairs deprives them to get equitable share in all social services including healthcare services of the society. It is also assumed that the national health policy and programs are mostly gender bias; because female members of the country lack political power. Thus, it may be hypothesized that women's political empowerment enables them to get proper share in healthcare including reproductive healthcare. Therefore, this chapter deals with how and to what extent women's access to reproductive healthcare depends on women's political empowerment. In order to do that some important areas of political empowerment have been identified and assessed their impact on reproductive healthcare has been assessed.

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8.2: Constitutional Provisions of Women's Rights

The Constitution of Bangladesh is of the most important custodian of citizen rights including women's rights. As a liberal-democratic constitution, it attempts to safeguard the right and liberty of the people irrespective of caste, creed, sex, religion, ethnicity, and so on. Participation of women in all walks of life and their welfare have been emphasized in the Constitution. For that purpose, the Constitution of Bangladesh has made the following provisions and articles:

Art. 10: Steps shall be taken to ensure participation of women in all spheres of national life.[4]

Art. 15: The State makes a provision "the provision of the basic necessities of life, including food, clothing, shelter, education and medical care."[5]

Art. 18(1): The State shall regard the raising of the level of nutrition and the improvement of public health as among its primary duties.[6]

Art. 28(1): The State shall not discriminate against any citizen on grounds only of religion, race, caste, sex or place of birth.[7]

The Constitution of Bangladesh is merely a written document, a promise to do something, a guiding principle but its provisions are hardly materialized. Political authority has no capacity to implement its policies, promises and programs. Therefore, constitutional provisions in Bangladesh bear a little connotation. Particularly, in the case of the rural women all these provisions have little meaning. Because the women are not aware of the constitutional provisions and rights, and they have no relationship with the constitution as well as national politics. Of course, as a welfare state Bangladesh Government has attempted to promote people's health through its various policies and programs as well as related with the MGDs and PRSP. Therefore, the constitutional

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provisions about women in reality have little impact on the reproductive healthcare of the rural women.

8.3: Holding Political Position on Healthcare

In any society or social structure, political position has great importance to get any social services. People with political position or power get more privilege and patronage than the powerless people. Job, status, money, education, wealth, honor, and other services and facilities can be attained by using political power or political position. Most of the people do respect politically empowered people in the society and also feel fear about them. In Bangladesh, the people want to get more only through political power. It has negative impact on people's personal, familial and social life. But the scenario is to some extent different in the rural society of Bangladesh.

Most the village people stay away from politics. The villagers are not educated and they live very simple lives and they are not much critical in their thinking and they understand a very little about political matters. The political environment of Bangladesh is passing through a terminal and unstable situation which are reflecting in the socio-economic, socio-cultural and livelihood of Bangladesh as well as development process. In recent time, the media of Bangladesh has played a significant role to make aware the rural people about their rights, politics, and the upheavals of socio-economic situation of the state. Rural people work hard to manage their food, they sleep at night and reproduce many children—this is their usual life. Of course, some changes are taking place in the rural society. The lives of the rural women are worse than men. Male people go outside of home for their works and they have enough scope to go anywhere anytime and can know about outside world. But the rural women live their lives in such a way that they cannot do such things like the male members

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of the family. As a result, they have no political information to be conscious politically.[8]

Hazipur is a typical village of Bangladesh which represents all other villages of Bangladesh. Like all other villages the women of *Hazipur* are less educated, engaged in household activities, reproduce a number of children, take care of all the family members, feed the pet animals, cook food for all, wash cloths—these are their routine works in lives. So, there is no scope to be politically conscious and active. They are very much apathetic to politics, news, clash, coercion between political groups or any happening at national level; because the women of *Hazipur* usually do not hold any political position. None is also politically active. It may be noted with importance that political institution and position for women's participation is almost absent at grass root level except the Union *Parishad.* Particularly, the Local Government (Union *Parishad*) Second Amendment Act 1997 has introduced the direct election system of the seats reserved for women. Marium Begum, 38 years age, was the only Union *Parishad* Member of *Hazipur*. But in reality female Union *Parishad* member usually cannot possess any power at all although they are elected by the people. Even in the Union *Parishad* they subordinate the male members of the *Parishad.*

Most of the women of *Hazipur* and their husbands generally do not hold any political position; therefore, healthcare of the rural women has not been influenced by holding political position or political power. In most of the cases, political power and political positions have not much impact on getting healthcare or medicare facilities in the rural areas of Bangladesh. Because, the rural people are far more away from politics and they live very much simple lives. The study has founded that the wives of political activists also deprived of adequate healthcare. It is because of the fact that women's healthcare is determined by the rules of family and society which govern these.

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8.4: Relationship with Local Leaders on Healthcare

Good relationship with political leaders help get many things in social life like employment, education, money, healthcare facilities, honor, security, comfort, and so on. As a result, most of the people try to maintain good relationship with leaders. If anyone has a relative who is a political leader, he or she has great opportunity in everywhere. But the scene is to some extent different in the rural areas of Bangladesh. Simple life leading does not permit the rural people to go to politics or political leaders. But there are some people closely related with local leaders to get extra privilege in dangerous situation, crisis moments, getting proper medicare facilities, money, social security etc. The rural people sometimes also show honor to the close people of local leaders. So, relationships with local leaders help to some extent get the facility of healthcare.

Certain points are to note here in order to understand the impact of closeness to the local leaders on women's healthcare: (1) The rural women are very apolitical and they do not expect any pay-off from political game rather they are dependent on their respective families; (2) Local leaders have no healthcare services or facilities to allocate to the people particularly to the women; (3) If they have any opportunity to allocate something they prefer their relatives and close persons to other persons. Therefore, allocated justice is not possible by them; (4) In some health programs initiated by the government like vaccination program for the children the local leaders particularly the chairmen and members of the Union *Parishad* circulate and cooperate to make the program a success. All these conditions lead us to conclude that local politics and local leaders have very little things to do for women's reproductive healthcare. Therefore, maintaining good relations with local leaders does not bring any impact on women's reproductive healthcare.

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Case Study 1

Zamila Begum, 45 years old, has 4 children. In times of crisis period, clash, conflict, faction, disease or such kind of problems, she did not find the local leaders who could help her (Zamila) family. Zamila said that the chairman lives in another village and does not co-operate the people of *Hazipur* in times of need. Sometimes Zamila and her family badly needed the help of the chairman and local leaders of the village but failed to get the help.

8.5: Voting on Healthcare

Vote is the most strategic right of all citizens in a democratic state. This is one kind of proof of citizenship in a particular state. All the citizens of Bangladesh above 18 years age, mentally and physically in good health, are not related with criminal activities against the state are eligible voters and can cast their votes in favor of their desirable persons or party in an election. The right of voting is equal for all irrespective of sex, class, caste, power, ethnic group, religion under the principle of "one man, one vote".

During fieldwork in *Hazipur*, I have found that most of the women above 18 years old are the voters and they cast their votes almost regularly. It should be noted here that for most of the time Bangladesh is ruled by two political parties which are known as AL and BNP. Women of *Hazipur* also know the names of two main leaders of the parties: Hasina (Sheikh Hasina) of AL and Khaleda (Begum Khaleda Zia) of BNP. Most of the women of *Hazipur* cast their votes in favor of the two parties. They vote but many of them in fact do not know why their votes are necessary. They even do not know that their valuable votes elect the government of Bangladesh who rules the country for next 5 years.

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Case Study 2

Mazeda Begum, 50 years old woman, has 5 children. In each election she casts her valuable vote to a party. But she does not cast the vote to a specific party each time. According to her, she (Mazeda) should vote the party who does well for the people but no government does much good for the mass people and cannot reduce their poverty. As a result, she changes her voting choice each time. This is the technique taught by her husband. But she does not know how voting right can be used to protect her right including the right to healthcare.

Field data shows that 92.64% respondents (302) of *Hazipur* cast their votes regularly and only 6.75% (22) do not vote. It indicates that almost all eligible women voters vote regularly. Out of 302 voters who cast their votes regularly 61.92% of them have 1-2 children, 29.14 percent women have 3-4 children and 8.94 percent have more than 5 children. So, it can be said that there is no relationship between number of children and voting. Similarly we have assessed the impact of voting on some other elements of women's reproductive healthcare. All the available data and information lead us to conclude that voting power is hardly used for standard reproductive healthcare. The women are not aware of it and there is little scope to use this right in favor of using for healthcare.

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Photograph-8.1: Ajiron, No Meaning of Politics Even of Life to Her

8.6: Choices on Voting Decisions on Healthcare

It has been observed that though most of the women voters cast their votes, they can hardly apply their own choices in voting decisions. They cast their votes according to the wishes of their husbands or the heads of the family or local leaders who must be a male member of the family and society. Interestingly, those women even do not willingly go to polling centre, they go at the instigation or by the order of the male member and also accompanied by their husbands or other male members. Their personal choices in choosing candidates and/or parties are deviated frequently.

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Table-8.1: Personal Choices of the Respondents in Voting Decisions

Personal choices in voting decisions	Total	Percentage
Yes	104	31.91%
Compromised	68	20.86%
No	154	47.24%
Total	326	100%

Source: Field Data 2012

Table-8.1 presents personal choices of the respondents in voting decisions. It shows that 31.91 percent women have personal choices in voting decisions, 20.86 percent have compromised decision and 47.24 percent have not personal choices in voting decisions.

Table-8.2: Distribution of Personal Choices of the Respondents in Voting Decisions by Number of Children

Personal choices in voting decisions	Number of Children			
	1-2	3-4	5+	Total
Yes	74 (71.15%)*	26 (25.00%)	4 (3.85%)	104 (31.91%)
Compromised	50 (73.53%)	14 20.59%)	4 (5.89%)	68 (20.86%)
No	88 (57.15%)	48 31.17%)	18 11.69%)	154 (47.24%)
Total	212 (65.04%)	88 (26.100%)	26 (7.98%)	326 (100%)

Source: Field Data 2012
*Percentage of column within bracket

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Table-8.2 demonstrates that 73.53 percent women do compromise in voting decisions and they have 1-2 children, 71.16 percent women have personal choices in voting decisions and they have 1-2 children and 57.15 percent women who have no choice in voting decisions and they have 1-2 children. On the other hand, 5.89 percent women compromise who have more than 5 children; in this category only 3.85 percent women have personal choices in voting decision and 11.69 percent women have no choices. From the above mentioned figure it seems that the women who have their personal choices in voting decisions have less number of children. On the other hand, the women who have less personal choices in voting decisions they have more number of children. The result of the chi-square demonstrates that there is a relationship between the two variables. At 5% sig. (level of significance) and 4 df. (degree of freedom) the table value is 9.48 and calculated value is 10.24 which is bigger than the table value. Therefore, the null hypothesis to be rejected, that means, there is a relationship between the two variables.

Table-8.3: Distribution of Personal Choices of the Respondents in Voting Decisions by Planning of Child Bearing

Personal choices in voting decisions	Planning of Childbearing		
	Yes	No	Total
Yes	64 (61.54%)*	40 (38.47%)	104 (31.91%)
Compromised	32 (47.06%)	36 (52.95%)	68 (20.86%)
No	34 (22.08%)	120 (77.93%)	154 (47.24%)
Total	130 (39.88%)	196 (60.13%)	326 (100%)

Source: Field Data 2012
*Percentage of column within bracket

Table-8.3 demonstrates that 47.06 percent women who did compromise in voting decisions their child bearing is planned. In this category, 61.54 percent women have personal choices in voting decisions and 22.08 percent women who

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have no choice at all in voting decisions and their child bearing is planned. On the other hand, 52.95 percent women who make compromised decisions in voting their child bearing is not planned. In this category, 38.47 percent women have their personal choices in voting decisions and 77.93 percent women have no personal choices and their child bearing is not planned. So, there is a close relationship between personal choices in voting decisions and planning of child bearing. The result of the chi-square demonstrates that there is a relationship between the two variables. At 5% sig. (level of significance) and 2 df. (degree of freedom) the table value is 5.99 and calculated value is 42.16 which is bigger than the table value. Therefore, the null hypothesis to be rejected, that means, there is a relationship between the two variables. It is because of the fact that both the decisions of voting and child bearing are by nature of family decisions, and both are generally made by husband and wife in a family.

Table-8.4: Distribution of Personal Choices of the Respondents in Voting Decisions by Consultation with Doctor

Personal Choices in voting Decisions	Consultation with Doctor		
	Yes	No	Total
Yes	52 (50.00%)*	52 (50.00%)	104 (31.91%)
Compromised	42 (61.77%)	26 (38.24%)	68 (20.86%)
No	50 (32.47%)	104 (67.54%)	154 (47.24%)
Total	144 (44.187%)	182 (56.83%)	326 (100%)

Source: Field Data 2012
*Percentage of column within bracket

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Table-8.4 shows that 61.77 percent women who make compromised decisions in voting matters did consult with doctor during pregnancy and 50.00 percent women who have personal choices in voting decisions did consult with doctor. On the other hand, only 32.47 percent women who have no choice or own opinion in voting decisions consult with doctor during pregnancy. Similarly, 38.24 percent women who did compromise in voting decisions did not consult with doctor during pregnancy, 50.00 percent women who have personal choices in voting decision did not consult with doctor during pregnancy. On the other hand, 67.54 percent women who have no choice in voting decisions did not consult with doctor during pregnancy. So, there is a close relationship between personal choices in voting decisions and consultation with doctor during pregnancy. The result of the chi-square demonstrates that there is a relationship between the two variables. At 5% sig. (level of significance) and 2 df. (degree of freedom) the table value is 5.99 and calculated value is 18.54 which is bigger than the table value. Therefore, the null hypothesis to be rejected, that means, there is a relationship between the two variables. It is because of the fact that both decisions are family decisions and made almost in similar way.

The study has assessed the impact of personal choice in voting decisions on taking nutritious food during pregnancy. It has been found that personal choices in voting decisions of women has little impact on taking nutritious food during pregnancy. The study has assessed the impact of independent voting decisions on other elements of reproductive healthcare. It reveals more or less positive impact of voting decision on women's health and healthcare.

8.7: Political Activism on Healthcare

During fieldwork in *Hazipur*, it has been found that no woman is a political activist. Most of the people of rural areas are not interested in politics or political power or position. They are not related to politics or political power or position. They are not involved with politics directly; they only cast their votes to their

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desirable candidate and/or party in an election. The condition of women is worse than men. They are no more related to politics in their whole life and not involved with any political upheavals.

As political activism is not much observed in *Hazipur*, it has not much effect on the lives of the rural people generally women. The women of rural society has predominated by tradition and are not permitted to come out of the boundary of home; and they work in household and enjoy very simple lives with husband and children and sometimes with parents-in-laws. So, they have not enough time and scope to think about politics, political power and position, political activism. As a result, their medicare facilities and healthcare are not related with political activism. Some once husbands are engaged in political activities but usually these do not affect the healthcare of women at large. Any positive outcome from political power is normally used for the betterment of male members of the family. In a gender segregated family system any well-being benefits men more than women. It has found that the wife of a political leader seriously deprived of adequate reproductive healthcare services. During fieldwork in the village some women stated:

> We are the poor people who eat hand to mouth; we are not more interested in politics. Even we are not interested anymore about the governmental changes because both Hasina (Sheikh Hasina) and Khaleda (Begum Khaleda Zia) whoever comes in the government, we do not get any betterment or new things. So, politics is not for our well-being.

8.8: Conclusion

In recent years in Bangladesh both the ruling and opposition parties exercise their political power in such a way that a huge numbers of people get benefits

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from political game. In the urban areas and also in peri-urban areas many people lead their livelihoods with politics. But the rural areas are almost free from these political activities. Both men and women are not very much interested and related with political activities. The people of the rural areas only know that they have to cast their votes during any election. They have no good relationships with local leaders and they only go to the elected local members and chairman in times of clash and faction. So, political power and political activities are no more helpful for getting healthcare facilities in the rural areas of Bangladesh. As a result, the study reveals a very insignificant relationship between politics and women reproductive healthcare in the study area as well as in the context of rural Bangladesh.

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4. *The Constitution of the People's Republic of Bangladesh* (As modified up to 30th April, 1996), Ministry of Law, Justice and Parliamentary Affairs, Dhaka, 1996, p. 10.
5. *Ibid*, p. 12.
6. *Ibid*, p. 14.
7. *Ibid*, p. 18.
8. In the literature politics, this type of culture is called "minimal" or 'low' political culture.

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Chapter 9

Conclusion

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Chapter 9

Conclusion

An attempt to use holistic approach to deal with women empowerment is useful and essential from many considerations; because it is integrally related with society, culture, religion, economy, politics, and so on.[1] As a result, holistic approach has been used in this study. Similarly, women's reproductive healthcare also needs multifarious approaches to be dealt with; because it is not only biological phenomenon rather involved with society, culture, religion, economy, politics, and so on. Anthropologically it may be noted that women empowerment and women's reproductive healthcare are intrinsically very much interrelated and interdependent. Of particular, the access to standard reproductive healthcare largely depends on women empowerment.

The study has explored that both women empowerment and reproductive healthcare conditions in rural Bangladesh are very negligible and below standard.[2]Under the patriarchic rule of the family and society, women are in most cases suppressed, oppressed and deprived. The study reveals that most of the rural women are deprived of standard reproductive healthcare available in the country. Only a very few women can avail of standard reproductive healthcare. But what are the factors contribute to such differential access to standard reproductive healthcare? The study has hypothesized that it is women empowerment along with other factors contribute to this process.[3]Generally, empowered women can have access to standard reproductive healthcare, and powerless women cannot have access to standard reproductive healthcare rather they have access to traditional reproductive healthcare. Almost in similar way, the access to standard reproductive healthcare exerts impact on women

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empowerment that means the two variables are significantly interrelated and interdependent. The study has subsequently tested these hypotheses and explored, described and analyzed the results as well as qualitative and quantitative which is made and integrated innovation and collaboration.

Women empowerment and particularly empowerment in family domain has significant impact on women's reproductive healthcare. As a woman is to live in family and she is very much a member of the family. A woman's life in rural Bangladesh is traditional and simple. Rather whole life of a woman is dominated, regulated and controlled by the rigid rules and regulations of the family. The study reveals that female members have no effective and meaningful participation in almost all family decisions. Healthcare decision is also a family decision generally made by male head of the family. Overall conditions in the rural families are hardly conducive to women's access to standard reproductive healthcare. Therefore, women empowerment in family domain in a significant factor in accessing standard reproductive healthcare.[4]

The study has depicted that social empowerment in accessing to standard reproductive healthcare has not too significant impact.[5] It has been found that women of rural Bangladesh can hardly hold any social positions rather key social positions are monopolistically held by male members of the society. Even the women who hold significant social positions, they cannot use the positions in favor of accessing standard reproductive healthcare. It is because of the fact that they have little opportunity to run the positions independently and indifferently from the influence of male members of the family and society. Data demonstrates that husband's social positions do not bring any positive outcomes for wives' reproductive healthcare. Therefore, the study intends to conclude that holding of any social position either by a woman herself or her husband does not facilitate women to access to standard reproductive healthcare.

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Empowerment in economic life is so significant that all walks of one's life is heavily dependent on his/her economic performance in the family as well as society at large. Consequently, a woman's reproductive healthcare is also very much dependent on this element. The study reveals that almost all the women in the study area are economically dependent on male members of the family. They do not have any socially recognized income; because they are employed in unpaid social reproductive sector including household works.[6] In fact, women's works in the rural society are traditionally confined to biological and social reproduction only. Even in the case of cash money earner women, access to standard reproductive healthcare is not satisfactory. It is because of the fact that the women have a very little control over the decisions of family income and expenditure rather this key decision is monopolized by the male members particularly the head of the family and/or husband. A woman cannot spend even her own income for her own purpose. In this context, patriarchic control and domination over the economic decisions in a family makes women less empowered and consequently more vulnerable to male members for reproductive healthcare as well other aspects of healthcare.

The study has examined the impact of political empowerment on women's reproductive healthcare. It has been found that the rural people are basically apolitical and in certain cases they are seasonal political. The rural women have virtually no relationship with both local and national politics other than voting in certain elections. Even their voting is also in most cases client voting.[7] Women's personal choices are hardly reflected in their voting decisions rather their choices are shaped and controlled by the male members like husband, head of the family, local leaders etc. Thus, voting right, a strategic political power endowed by the country's constitution, cannot properly be utilized in achieving women's interests. Over all conditions in rural Bangladesh are not conducive for women

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to be political and politically empowered. Women's subordinate role both in family and society is reflected in political life as well. As a result, the women in rural Bangladesh are not politically empowered in true sense. Such political powerlessness makes women dependent on men to get the facilities allocated by the state for them. Women's reproductive healthcare service is one of those facilities of which women are deprived lacking of political power.

It has been found that the empowered women have easy access to standard reproductive healthcare and the women who have standard reproductive healthcare are mostly empowered. In the context of rural Bangladesh, this relationship is not always visible rather subtle. Empowered women have easy access to all the social services available in the society including reproductive healthcare. On the other hand, the access to reproductive healthcare has indirect implications on empowering women but this factor alone can play little role in one's empowerment rather other factors are required for this goal. Therefore, women empowerment is viewed as a whole and reproductive healthcare is a part of the whole.

Empowering the rural women is an urgent need for Bangladesh and to achieve this goal through ensuring standard reproductive healthcare may be a policy option. But in order to do that the whole gamut of the society should be changed. Because reproductive healthcare is not an isolated phenomenon rather it is very closely related with other factors of the society including family system, culture, values, beliefs, religion, and so on. The rural society of Bangladesh is the victim of extreme poverty, health facilities are inadequate and traditional, and unequally distributed among diverse sections of the population of which women are the most deprived ones. Secondly, the socio-cultural conditions of rural Bangladesh are not conducive to women's access to standard reproductive healthcare. As a result, the whole environment prevailing in the rural society makes a vicious

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circle of deprivation and discrimination in regard to women's reproductive healthcare. In order to ensure standard reproductive healthcare for the rural women it is essential to demolish the circle the backwardness, deprivation and discrimination.

The present study, therefore, has explored some unearth phenomena on women empowerment and reproductive healthcare in the context of rural Bangladesh. The objectives and hypotheses stated at the beginning of the study have been dealt with properly. The study reveals that the rural women are mostly powerless and voiceless in the family, society and state. Such a condition obstructs them to access to standard reproductive healthcare. In particular, women's powerlessness in the family has significant negative impact on reproductive healthcare; and powerlessness in the family creates vulnerability in other domains of life like economic, social and political. Therefore, women empowerment should be emphasized in order to ensure their access to standard reproductive healthcare. In the process, various measures should be taken to root out the patriarchy prevailing everywhere in the rural society. It will make the women free from exploitation and discrimination made by the family, society and state. At the same time, priority will be given to make the rural women economically solvent with education and betterment as well capable to raise voice and purchasing capacity to buy the healthcare services and others entitlement. Above all, reproductive healthcare facilities in the rural area of Bangladesh should be expanded and easy accessible for the women; and for this purpose necessary policy should be formulated and implemented.

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1. For diverse approaches to health research, See, Ann Bowling, *Research Methods in Health: Investigating Health and Health Services*, Open University Press, Buckingham, Philadelphia, 1997.
2. All indices of both women empowerment and reproductive healthcare at national level data demonstrate the fact. For details, See, *Bangladesh Demographic and Health Survey 2011*, National Institute of Population Research and Training (NIPORT), Dhaka, 2012 and, *Gender Statistics of Bangladesh,* Dhaka, 2007.
3. Other factors include the socio-demographic variables of individual women and availability of health services which have been dealt with in this study.
4. The study reveals that this factor is the most dominant one in accessing to standard reproductive healthcare although other factors are also important.
5. The rural women are socially excluded and social power has little to do with women's reproductive healthcare.
6. For an interesting analysis, See, Shamim Hamid, *Why Women Count: Essays on Women in Development in Bangladesh*, The University Press Limited, Dhaka, 1996.
7. In patron-client relation, a client votes according to the will of his/her patron which is called client voting.

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Questionnaire

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Questionnaire

1. Name:.....

2. Age:.....

3. Education:.....

Family Affairs

4. Do you have access everyday family decisions with husband? Equal Partial No

5. Do you have access to everyday family income decisions? Equal Partial No

6. Do you have access to everyday family expenditure decisions?

   Equal Partial No

7. Are you close to head of the family? Very close Close No

8. What is the family size? 1 2 3 4 5 6 7+

9. Are you open to other family members? Very Open Open No

10. Do you have access to healthcare decision? Equal Partial No

11. What is the nature of family authority? Liberal Moderate Conservative

12. What is the family's nature of religiousness? Secular Moderate Religious

13. Do you have the right to physical mobility? Yes Conditional No

Social Empowerment

14. What is your social position? Formal leader Informal leader Ordinary

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15. What is your husband's social position? Formal leader Informal leader Ordinary

16. Do you observe purdha? Yes Sometimes No

17. Can you participate in social gathering independently? YesSometimes No

18. Can you participate in religious gathering independently? Yes Sometimes No

19. Can you participate in Shalish independently? Yes Sometimes No

20. Do you have the right to physical mobility? Anywhere Village area Para Bari No

21. At what level you are religious? Secular Moderate Religious

22. Are you a member of any social organization like club, samittie etc.? Yes No

Economic Empowerment

23. Are you self income or dependent? Self income Partial Dependent

24. What is your profession?.....

25. What is your husband's profession?.....

26. What is your annual family income? .....

27. What is your annual self income? .....

28. Do you possess any land? Yes No

29. Do you possess any key resource other than land? Yes No

30. Do you have control over your own income? Yes No NA

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31. Can you borrow any loan? Yes No No need

32. Do you have the right to expenditure? Yes No No need

Political Empowerment

33. Do you have any political position? Yes No

34. What is the political position of your husband/family members?.....

35. Do you have good relations with Chairman/member/political leader?

    Yes No

36. Do you vote? Regularly Sometimes No

37. Do you have personal choices in voting decision?

    Yes Compromised No

38. Do you willingly go to polling centre? Yes Compromised No

39. Are you a political activist? Yes No

Healthcare

40. Number of pregnancies : .....

41. Number of children : .....

42. How many children dried? No 1 2 3 4

43. Is /were your child/children bearing planned? Yes No

44. Who decide the time of pregnancy? Husband Wife Both None

45. Who decide the number of babies? Husband Wife Both None

46. Did you consult a doctor/nurse/health worker during your pregnancy?

    Yes No

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47. Did you follow the advice of a doctor? Yes Sometimes Could not NA

48. After how many months of your pregnancy you consulted with a doctor?

    3 4 5 6 7 NA

49. Who uses contraceptives? Husband Wife None

50. What type of problems you faced during your pregnancy period?

    a) b) c) d)

51. What type of necessary measures you took to solve those?

    a) b) c) d)

52. Did your family members help you during pregnancy?

    Comparative very comparative non comparative

53. Did you take nutritious food during pregnancy? YesPartial No

54. Did you take enough rest during pregnancy? Yes artial No

55. Did you get necessary recreation during pregnancy?

    Yes Partial No

56. Did you do regularly exercise / walking during pregnancy?

    Yes Partial No

57. Where did you delivery take place? Home Hospital clinicother

58. Who did perform your delivery?

    Doctor/ Nurse Midwife Family members Other

59. What type of measures were taken after delivery?

    a) b) c) d)

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60. How do you take shawl milk?

a) b) c) d)

61. What type of problems your newborn faced at first after its birth?

a) b) c) d)

62. What types of measures you have taken to solve these?

a) b) c) d)

63. Did you feel any depression during your pregnancy or /after delivery?

Yes No

64. In the family planning decision who usually take the decision?

Husband Wife both Other

65. Do you have any opinion/wish of your own on your intercourse?

Yes Sometime No

66. Who takes the decision of in time of inter-course?

Husband Wife Both

67. Does your husband give value to your wishes during the intercourse?

Yes Sometime No

68. How do you manage your malnutrition?

a) b) c) d)